Emergency Medical Advisory Group (EMAG)

Meeting Agenda
August 11, 2022
2:30 PM – 4:00 PM

Meeting Location:
Join Zoom Meeting
https://us06web.zoom.us/j/82434475443?pwd=UXV2blpPM3o1eFlqRm4vcmpRWjRydz09

Phone Dial In: 1.669.900.6833
Meeting ID: 824 3447 5443
Passcode: 220252

Topic	Time
Welcome, Introductions, and Agenda Review – *David Magnino* • Materials Review • Additional Agenda Items for Discussion • Other Member Announcements	2:30 – 2:40
Approval of April Meeting Minutes – *Stephanie Mello* – ACTION ITEM	2:40 – 2:45
EMAG Charter Review – *David Magnino*	2:45 – 2:55
EMS Committee Updates – *Hernando Garzon, MD* • Data Presentation: STEMI, Stroke, Trauma, CARES, APOT	2:55 – 3:05
COVID Update/Wrap Up – *Hernando Garzon, MD*	3:05 – 3:15
Open Discussion/Key Items – *EMAG Participants* • Work Group Updates – *David Magnino* • Computer Aided Dispatch (CAD) Interface – *David Magnino* • New State Regulations (Community Paramedicine & Transport to Alternate Destination) – *David Magnino* • Budget Update –*David Magnino*	3:15 – 3:45
Public Comment: One comment per person/organization, limited to two minutes.	3:45 – 3:50
Closing Remarks & Adjourn – *David Magnino* • Future Meetings: In Person or Virtual	3:50 – 4:00
Next Meetings • Thursday, October 13, 2022 / 2:30 PM – 4:00PM • Thursday, December 8, 2022 / 2:30PM – 4:00PM	

For more information, please visit the Emergency Medical Advisory Group website at:
https://dhs.saccounty.net/PRI/EMS/Pages/Emergency-Medical-Advisory-Group.aspx

Sacramento County Emergency Medical Advisory Group

Meeting Minutes
April 14, 2022, 2:30 PM – 4:00 PM

Meeting Held Electronically
Zoom Video Conference
https://us06web.zoom.us/j/82434475443?pwd=UXV2blpPM3o1eFlqRm4vcmpRWjRydz09
Phone Dial In: 1.669.900.6833
Meeting ID: 824 3447 5443. Passcode: 220252

ADVISORY GROUP MEMBERS			
	ALS Ground Transport Providers, Public – Barbie Law, Sac Metro Fire	X	Hospital System – Dr. J. Douglas Kirk, MD, UC Davis Health
X	ALS Ground Transport Providers, Private – Karl Pedroni, American Medical Response (AMR)		Law Enforcement – Lt. Shaun Hampton, Sheriff's Office
X	ALS Air Transport Providers – Mike Kaslin, REACH Air Medical	X	Training Provider – Jason Hemler, CSUS
	BLS Providers, Public – James Hendricks, Herald Fire District	**EX-OFFICIO MEMBERS**	
X	BLS Providers, Private – James Pierson, Medic Ambulance		County Primary Health Division – Sandy Damiano, PhD
X	Hospital System – Michael Korpiel, Dignity Health	X	County EMS Administrator – David Magnino
X	Hospital System – Michael Scates, Kaiser Permanente	X	County EMS Medical Director – Hernando Garzon, MD
X	Hospital System – Dr. Kevin Smothers, MD, Sutter Health	**GUEST PRESENTER**	
		X	Brian Jensen, Hospital Council

Advisory Group Members in Attendance: 8 – *Quorum present*
Public/Guests in Attendance: 8

Staff: Stephanie Mello

Sacramento County Emergency Medical Advisory Group

Topic	Minutes
Welcome, Introductions and Opening Remarks- *David Magnino, EMS Administrator*	David Magnino welcomed advisory group members, guests, and members of the public, and reviewed the agenda and meeting materials. Agenda Review: Approval of February Meeting Minutes, EMS Committee Update, COVID Update, Wall Times. Materials: Approval of February Meeting Minutes, APOT Data. *Materials are posted on the website.* Link: https://dhs.saccounty.net/PRI/EMS/Pages/Emergency-Medical-Advisory-Group.aspx Additional Agenda Items for Discussion: EMAG Charter review, and Maddy/Richie Fund revenue. Other Member Announcements: None
Roll Call – *Stephanie Mello*	Stephanie Mello conducted roll call. *Quorum present.*
Meeting Minutes – *Stephanie Mello*	APPROVED – Advisory Group members had no changes to the February 10, 2022, draft meeting minutes. Meeting minutes were approved on a motion by Dr. Kevin Smothers and seconded by James Pierson. Approved by vote of members in Zoom chat.
EMS Committee Update – *Hernando Garzon, MD*	Dr. Garzon: Medical Advisory Committee/Operational Advisory Committee: Completed policy reviews/updates effective July 1, 2022. The Committees have issued summaries of the policies. The committees review clinical studies and discuss APOT issues. STEMI/Stroke: STEMI committee reviewed CARES data and updated policies based on the data and input from cardiologist committee members. Stroke data reported by seven (7) of the nine (9) stroke receiving hospitals. Working on data accuracy issues. Should have data outcome within the next 6-9 months. Michael Korpiel requested feedback on if the two (2) non-reporting hospitals are Dignity Health hospitals. The EMS Specialist will reach out to the two (2) hospitals and notify Dr. Garzon of any concerns. Trauma Review Committee: Trauma numbers and outcomes have remained stable through COVID.
COVID Update – *Hernando Garzon, MD*	Dr. Garzon: COVID Numbers: COVID impact throughout the State and in Sacramento is at its lowest point (below 3%) since the start of the pandemic. Daily admission are at an all-time low. West Coast is about 10 days behind the East Coast. There are a couple of variants causing most of the cases in New York. A late Summer/Fall surge is expected. CDC extended the emergency health order for another six (6) months until July 16, 2022, but no discussion at the State level to extend the State order past June 30, 2022. Dr. Kirk: It would be helpful to have advance notification if the 6/30/2022 will be extended so the hospitals can prepare. Michael Korpiel: County

	went from moderate to substantial in regards to COVID alert status. Dr. Garzon: This is probably based on the case numbers. Dr. Smothers: Positive testing is trending up on all patients. Hospitalizations are low.
Wall Times – Current and Post Executive Order *All*	State Surge Build Out: State supported hospital staff ended March 31, 2022. Because of the federal extension of the emergency order, hospitals can keep the state supported staff, if the hospitals pay for the staff. APOT Times: David Magnino shared a comparison report of CEMSIS APOT data submitted on ePCRs to data SCEMSA submits. APOT Workgroup Update: Workgroup continues to meet monthly. Kaiser Sacramento and Kaiser South shared their new ER work flow based on SCEMSA Policy # 5050. Mercy San Juan provided their work flow following the meeting which was shared with the workgroup. Workgroup meetings moving forward will be every other month, the day prior to the EMAG. Brian Jensen: Many groups are talking about wall times, COVID surges and potential solutions. Conversations include decompressions policies. Both diversion and wall times are symptoms of overcrowding in the healthcare continuum. Solutions for unsafe ED crowding could affect wall times. Hospital Council meetings with Fire Chiefs and SCEMSA and the current emergencies allowed for some flexibility in trying new things: Access and Refer – resulted in only a small number of patients meeting the criteria. Hospitals are experiencing high level workforce challenges leading to difficulties in providing patient care. There is a lack of facilities to discharge patients to (acute care, assisted care, etc.). We need to preserve our EMS capacity through innovated ideas: Alternate Destinations, MIH, CAD Interface, etc. Lots of different workgroups going on. Need to connect and align EMAG's efforts with the other group's efforts. APOT Medics: Brian Henricksen asked about hospitals not continuing with additional staff at the hospital's expense. Brian Jensen: Spoke to the importance of finding ways to offload patients quickly to hospital care, but it has to be commensurate with the improvements within the hospital itself (i.e. finding beds for the patients), and locating facilities to discharge patients to for post-acute care. Dr. Kevin Smothers: The APOT medics are helpful, but improving the backend (i.e. finding more beds) has more impact. Partnering with post-acute care facilities is helpful in freeing up beds. Still need to address the homeless and mental health patients who occupy beds. Brian Jensen: The backlog of patients who need to be conserved is also impacting the availability of hospital beds. Jimmy Pierson: APOT medics weren't meant to only address the hospitals' issues, but were also meant to relieve the EMS system and get ambulances back in the field. Computer Aided Dispatch (CAD) Interface: David Magnino: EMS received Board approval and is moving forward with onboarding three (3) private ALS providers and Fire. EMS should have data to share at June's EMAG meeting. Alternate Destinations: David Magnino: State regulations are out for another thirty (30) day public comment due by April 24, 2022. Once regulations become effective, SCEMSA will look into implementing them within Sacramento County.

Sacramento County Emergency Medical Advisory Group

	Maddy/Richie Revenue Review: David Magnino: Presented a chart showing the decline of Maddy/Richie revenue. Maddy/Richie revenue makes up 68% of EMS's revenue. The chart did not include the Maddy/Richie revenue designated by statute for payment of emergency physician claims and Sacramento County trauma centers payments. Richie Fund revenue was added in Fiscal Year 2016-17 and was projected to equal the Maddy Revenue within 18 – 24 months, which didn't happen. Instead, Maddy revenue is decreasing to meet Richie revenue. If the decline in Maddy/Richie revenue continues, the revenue will cease to exist by Fiscal Year 2030-31. Currently, County General Fund supports three (3) EMS positions, which makes those EMS positions susceptible to cuts during difficult economic times. Need to continue exploring additional revenue sources. EMAG Charter: David Magnino shared the EMAG Charter and acknowledged Dr. Kevin Smother's comments earlier in the meeting regarding the EMAG refocusing on the mission statement of the Charter. Dr. Kevin Smothers: EMAG needs to focus on the value EMS brings to the community, and how is it partnering with the facilities. Focusing on the value EMS brings to the community will make it easier for the group to support EMS. The group is supposed to be about quality improvement and the value of the services EMS provides to the community. Refocusing on the Charter will help this group get farther in discussion with those who fund EMS or are asked to help fund EMS
Public Comment	Cindy Myas: Funding EMS is the County's responsibility. The group may need to look for inventive, alternate solutions. Do we need to check in with the other EMS agencies and how they are funded?
Action Item(s)	Stroke Data Reporting: Dr. Garzon - Notify Michael Korpiel if Dignity Health hospitals' are not reporting stroke data. Data Reporting: Dr. Garzon - Prepare clinical data report for next meeting. Report back on data based quality improvement. Charter: David Magnino – Send EMAG Charter to members for review and discussion at June's meeting. Subgroup: Brian Jensen - Establish a subgroup to develop a document, as a united front, that lays out the system issues, identifies the pitfalls, identifies what has already been done, and pulls together solution areas.
Closing Remarks and Adjourn – *David Magnino*	David thanked everyone for participating in today's meeting and acknowledged the hard work of everyone in the group. With no additional business to discuss, the meeting adjourned at 3:54 PM, with a motion by Dr. Kevin Smothers and a second motion by Dr. Kirk.
Next Meeting	**Thursday, June 9, 2022 / 2:30 PM – 4:00 PM** https://us06web.zoom.us/j/82434475443?pwd=UXV2blpPM3o1eFlqRm4vcmpRWjRydz09 Meeting ID: 824 3447 5443

	Passcode: 220252

SACRAMENTO COUNTY

Emergency Medical Advisory Group Charter
November 14, 2019

Purpose

The Emergency Medical Advisory Group (EMAG) mission is to improve the delivery and quality of emergency medical services (EMS) to Sacramento County residents.

Scope of Work

EMAG is a higher level planning body than the EMS Agency committees and work groups. This group has a system's view from a leadership level. Areas of focus include the following:

- Quality Improvement
- Program Planning
- Fiscal Sustainability

There will be a brief report each meeting on the standing EMS committees and work groups. These include:

- Medical Advisory Committee
- Operational Advisory Committee
- STEMI Committee
- Stroke Committee
- Trauma Review Committee
- Technical Advisory Group

Values

- Collaboration
- Transparency
- Data driven recommendations

Meeting Guidance

Meetings are scheduled and the meeting calendar is posted on the EMAG webpage. Context and continuity of discussions is essential. Success of this advisory group depends on:

- Active participation
- Consistent attendance – Seated members must attend at least 50% of the meetings per year.
- Notifying designated staff if unable to attend.
- Providing input from a systems perspective.
- Providing subject matter expertise.

Meetings will be scheduled quarterly. All meetings will be open and will have designated time for public comment for non-seated individuals.

County staff will facilitate the meetings and maintain an EMAG webpage for meeting materials including agendas, handouts, minutes, and meeting calendars. Advisory Group members will review and approve meeting notes.

Action Items

The overall intent is to work toward consensus. However, the group will vote on items requiring action. Each voting member is entitled to one vote. Member alternates attending on behalf of a seated member are entitled to the member's vote. Decisions will be decided by a majority vote given there is a quorum (presence of greater than 50% of the seated members).

Any item requiring action will be placed on the agenda in advance of the meeting. The agenda will be distributed to members no later than one week prior to the meeting.

Representation

The Emergency Medical Advisory Group (EMAG) shall include EMS stakeholder representatives as noted below:

Representation	Seats
Advanced Life Support (ALS) Ground Transport Providers	2
ALS Air Transport Providers	1
Basic Life Support (BLS) Providers	2
Training Providers	1
Hospital Systems	4
Law Enforcement	1
Subtotal – Voting Members	**11**
Ex-Officio Members (Non-voting)	
DHS Primary Health / Emergency Medical Services (EMS)	3
Total Members	**14**

Alternates

Members may designate an alternate to attend meetings and act on their behalf when the seated member is unable to attend. Guidelines for member alternates include:

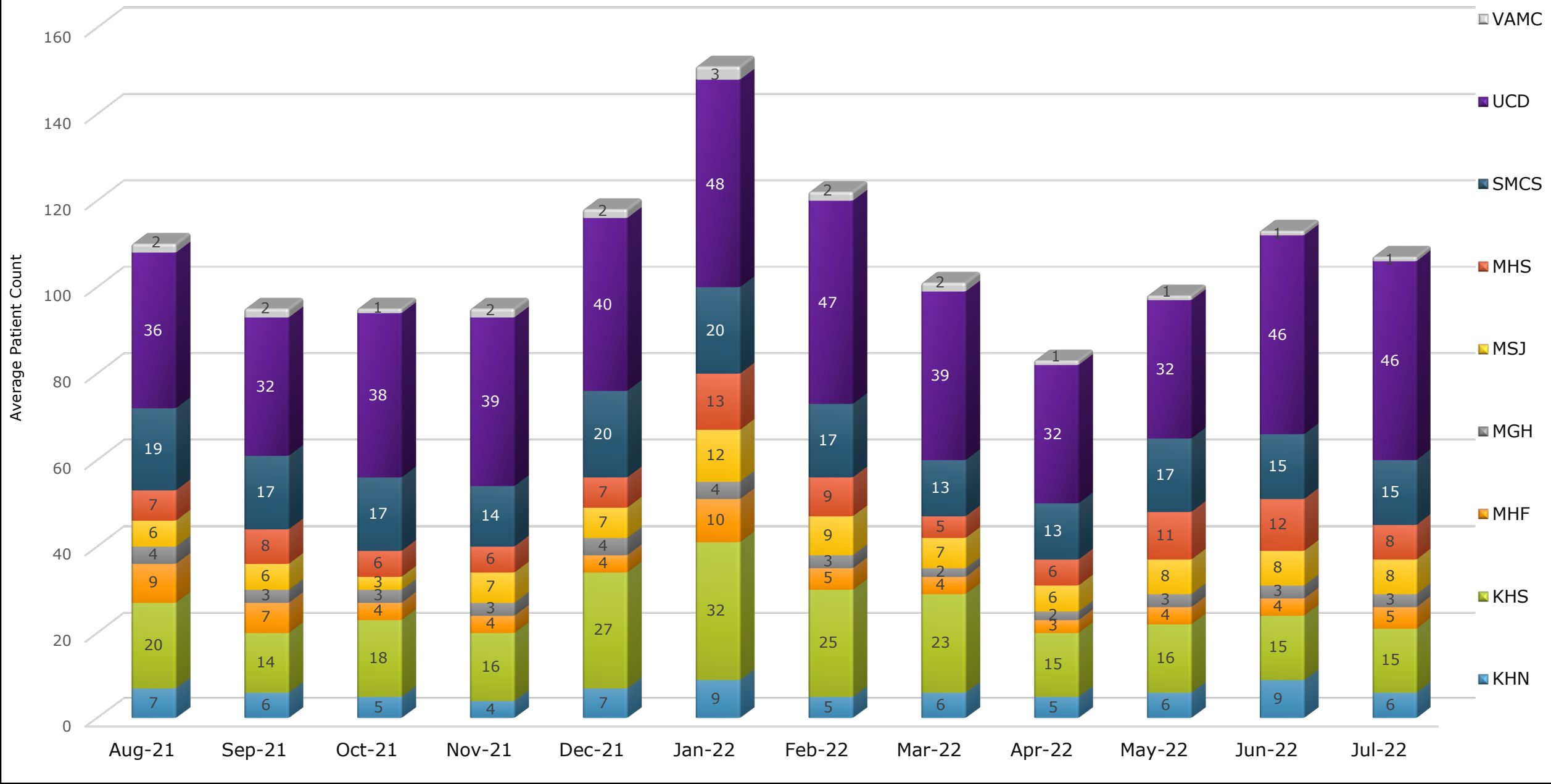
- Member may designate a specific alternate and notify county staff in advance. It is not appropriate to send someone other than the designated alternate.
- Designated alternate must be executive level, similar to other Advisory Group members.
- Seated member will share information with the alternate to ensure meaningful participation.
- When possible, alternates should attend meetings with the seated member in order to remain informed on topics. The alternate will sit in the audience.

SCEMSA Quarterly Reports

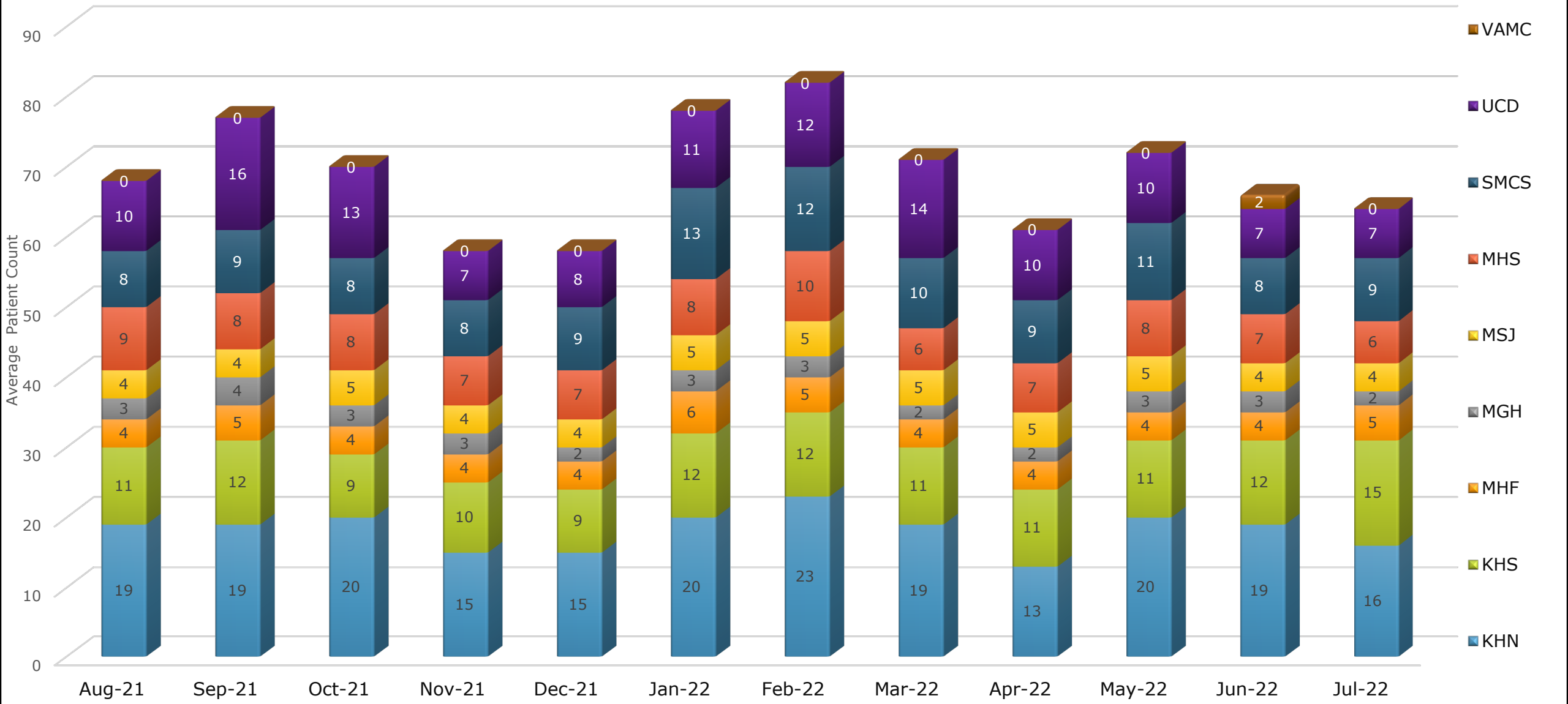
2022 - 2Quarter (April-June)

SCENE Calls (911-Response) – 2022- 2Quarter	Incident Count	Percentages	Notes
Total ePCRs received	75,662	100%	All records
Responses (911-Response)	59,908	79%	of total responses
Treated and Transported (of 911-Response)	**32,272**	**54%**	of 911 responses transported to the ED
Average Response Time of First Unit on Scene (PSAP to arrived scene)	0:12:23	N/A	
Average Response Time of First Unit on Scene (unit notified to arrived scene)	0:08:12	N/A	
Treated and Transferred Care or Assist (of 911-Response)	5,330	9%	
Transported By Law Enforcement (of 911-Response)	2	0%	
Dead at Scene (of 911-Response)	647	1%	
Cancelled (of 911-Response)	11,422	19%	No Patient found / No Contact / Prior to Arrival
RST -4 (Percentage of Response with Lights and Sirens)	37,928	63%	911 requests that included a lights and sirens response
RST -5 (Percentage of Transports with Lights and Sirens)	3,322	10%	911 request that included lights and sirens transport
IFT's	2,936	4%	Treated & transported
Primary Impressions of Scene calls treated and transported	**Incident Count**	**Percentages**	
Traumatic Injury (T14.90)	4,534	8%	
General Weakness (R53.1)	2,900	5%	
Abdominal Pain / Problems (GI/GU) (R10.84)	2,398	4%	
Behavioral / Psychiatric Crisis (F99)	2,067	3%	
Non-Traumatic Body Pain (G89.1)	1,702	3%	
No Medical Complaint (Z00.00)	1,601	3%	
ALOC - (Not Hypoglycemia or Seizure) (R41.82)	1,470	2%	
Respiratory Distress / Other (J80)	1,453	2%	
Chest Pain - Suspected Cardiac (I20.9)	1,197	2%	
Pain / Swelling - Extremity - non-traumatic (M79.60)	1,191	2%	
Nausea/Vomiting (R11.2)	1,041	2%	
Seizure - Post (G40.909)	921	2%	
Syncope / Near Syncope (R55)	921	2%	
Stroke / CVA / TIA (I63.9)	867	1%	
Sepsis (A41.9)	652	1%	
AMA/ Released / Refused / No Treatment of Scene Calls	**Incident Count**	**Percentages**	
AMA's	4,748	8%	
Patient Refused Evaluation / Care (without transport)	4,470	7%	
Patient Treated, Released (per protocol)	887	1%	
Total : AMA/ Released / Refused / No Treatment of Scene Calls	**10,105**	**17%**	

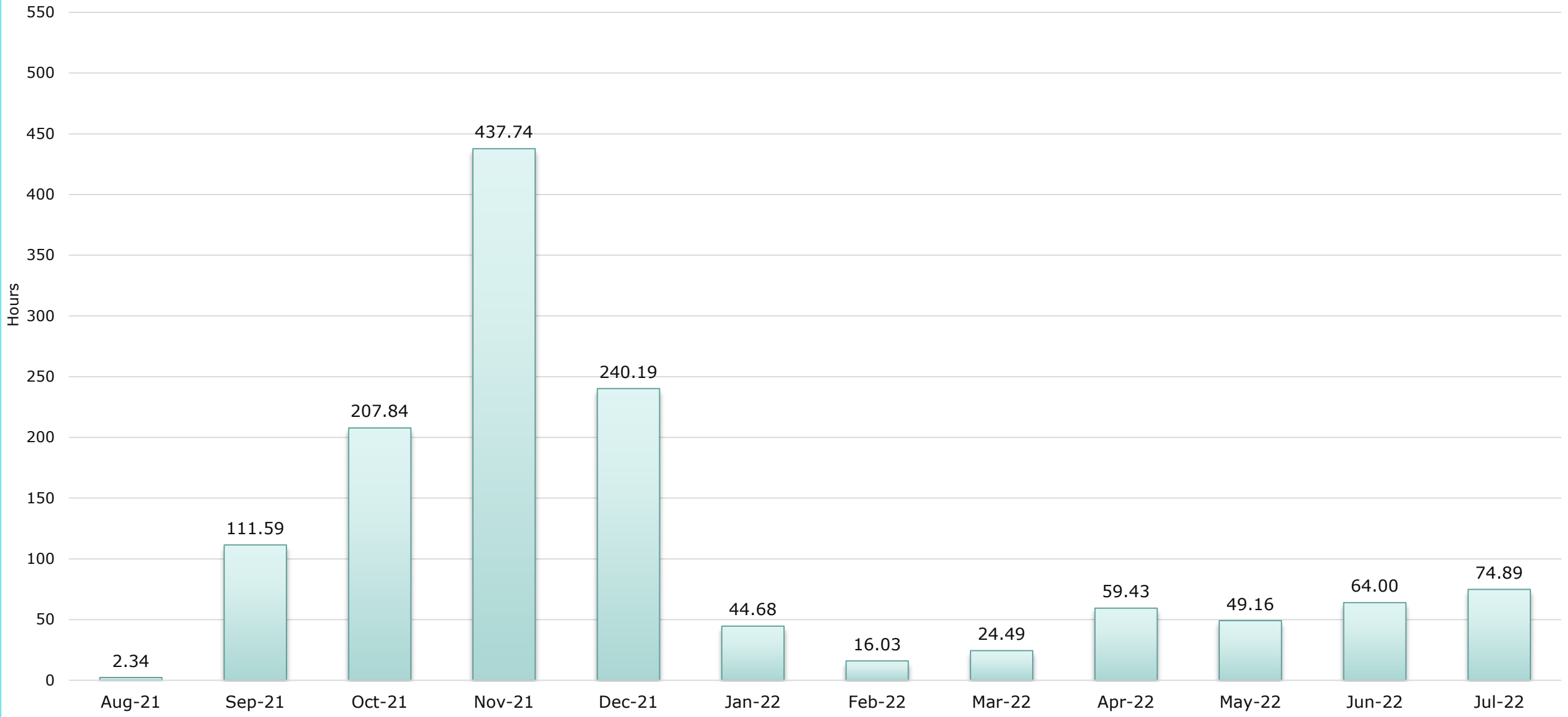
EMS: Patients on Medical Hold per Local Hospital Emergency Department



EMS: Patients Awaiting Placement into Psychiatric Facility per Local Hospital Emergency Department

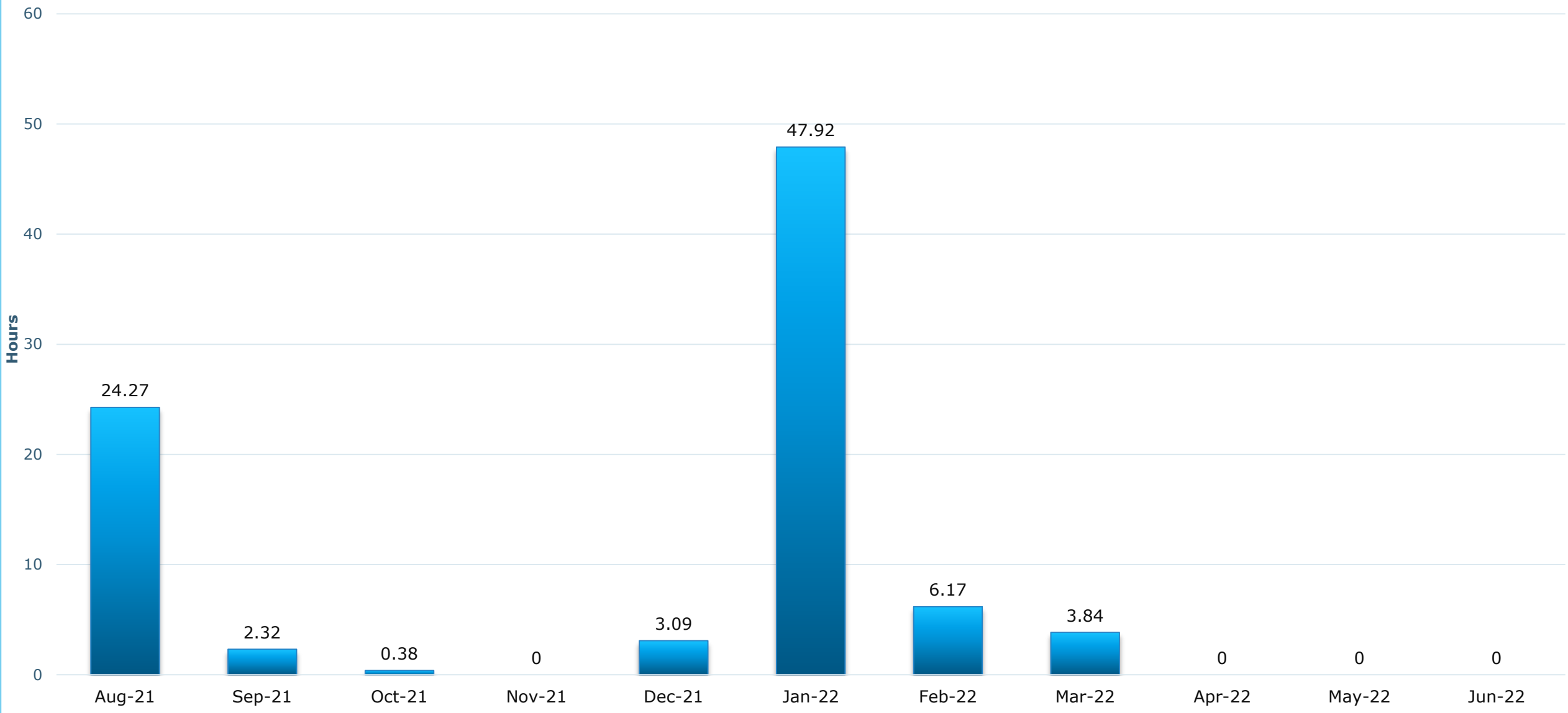


Total Advisory Hours per Month



Advisory Status Represents: CT or STEMI services unavailable / Power outage / Main power outage, using auxiliary power.

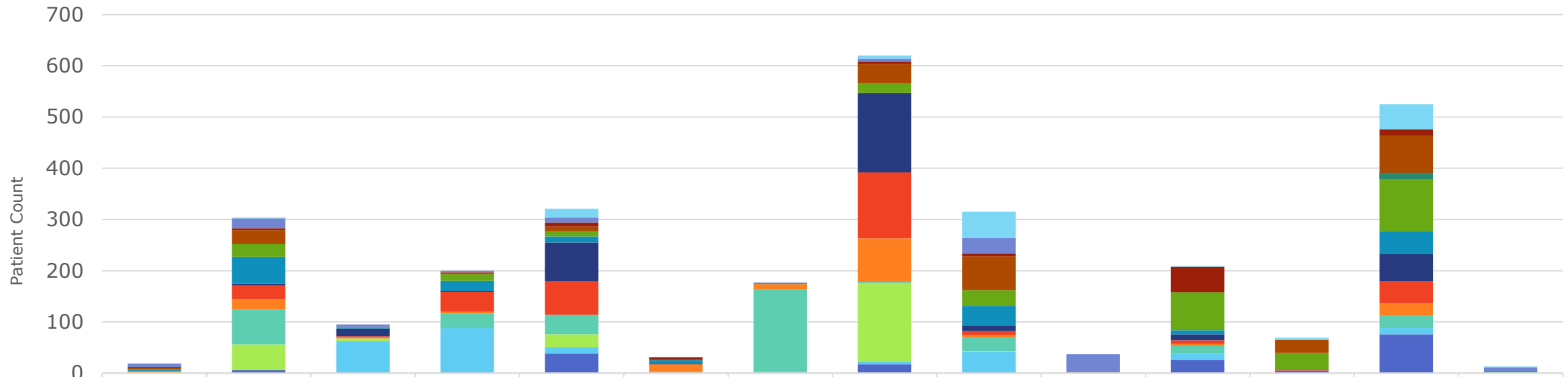
Total Internal Disaster Hours per Month



Internal Disaster Status: Damaged infrastructure / Hazardous materials incident / Sheltering in place / Loss of main and auxiliary power / Loss of water supply / On campus fire or explosion / On campus security threat other event requiring hospital evacuation.

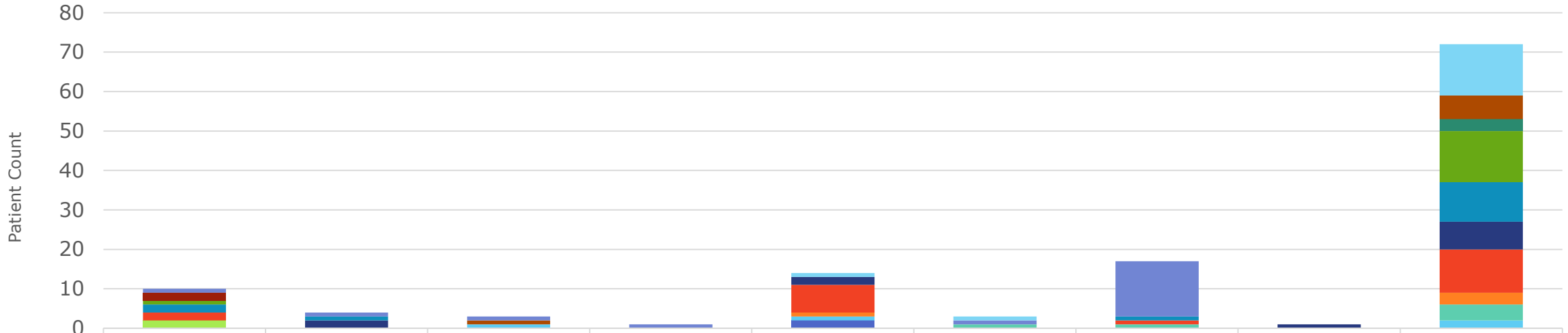
Interfacility Transports

Interfacility Transfers (IFTs) 2022-2Q - EMS Data



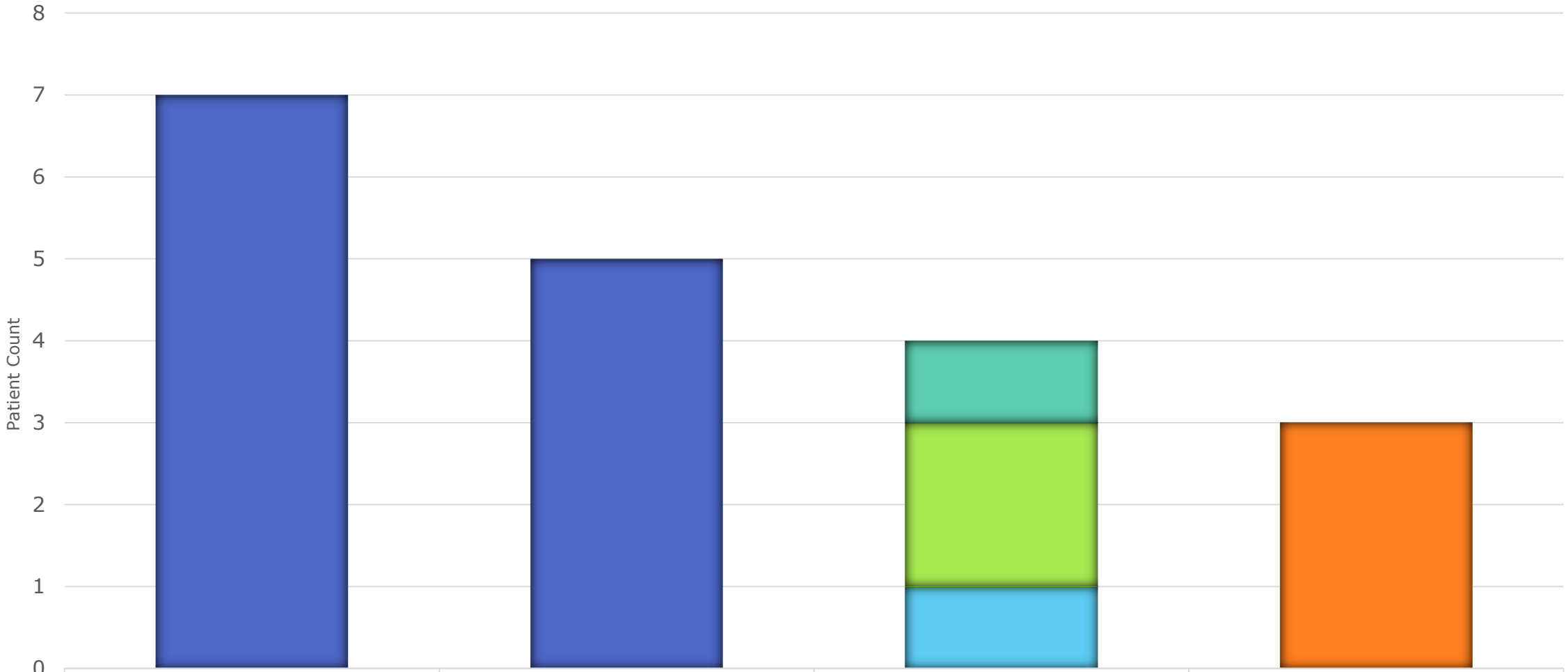
	Air	KHN	KHS	KRH	MGH	MHF	MHS	MSJ	OOA	Shriners	SMCS	SRMC	UCD	VAMC
VAMC- Send		2			17			6	51		1	4	49	2
UCD- Send	7	19	5	3	10	1	1	6	30	34				7
SRMC- Send	1	4		1	8	5	1	4	6		50		12	
SMCS- Send	4	27		3	9	1		38	66			25	73	1
Shriners- Send													12	
OOA- Send	1	25	2	13	10		1	19	31		74	32	102	
MSJ- Send	2	52	1	20	12	6			38	1	8		45	
MHS- Send		4	15	1	76	2		155	11		12		53	
MHF- Send		27	2	39	65		1	129	7	1	7	3	43	
MGH- Send	4	20	2	4		15	10	85	5		3		24	
KHS- Send		68		28	38	1	161	3	27	1	15		24	2
KHR- Send		50	5		25			152	2					
KHN- Send			63	87	13	1	1	6	40		13		12	
Air- Send		6		1	38		1	17	1		26	5	76	1

2022-2Q – Interfacility Transfers with Primary Impression of Trauma- EMS Data



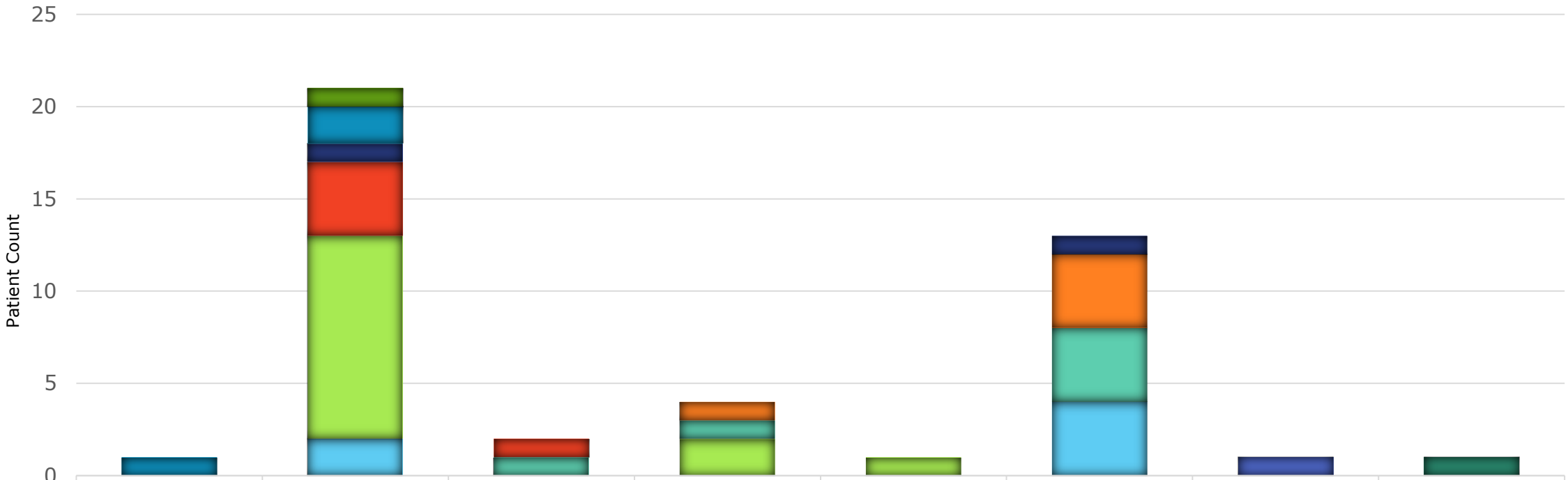
	KHN	KHS	KRH	MGH	MSJ	OOA	Shriners	SMCS	UCD
VAMC- Send					1	1			13
UCD- Send	1	1	1	1		1	14		
SRMC- Send	2								
SMCS- Send			1						6
Shriners- Send									3
OOA- Send	1								13
MSJ- Send	2	1					1		10
MHS- Send		2			2			1	7
MHF- Send	2				7		1		11
MGH- Send					1				3
KHS- Send						1	1		4
KHR- Send	2								
KHN- Send			1		1				2
Air- Send					2				

2022-2Q Interfacility Transfers (IFTs) - EMS Data



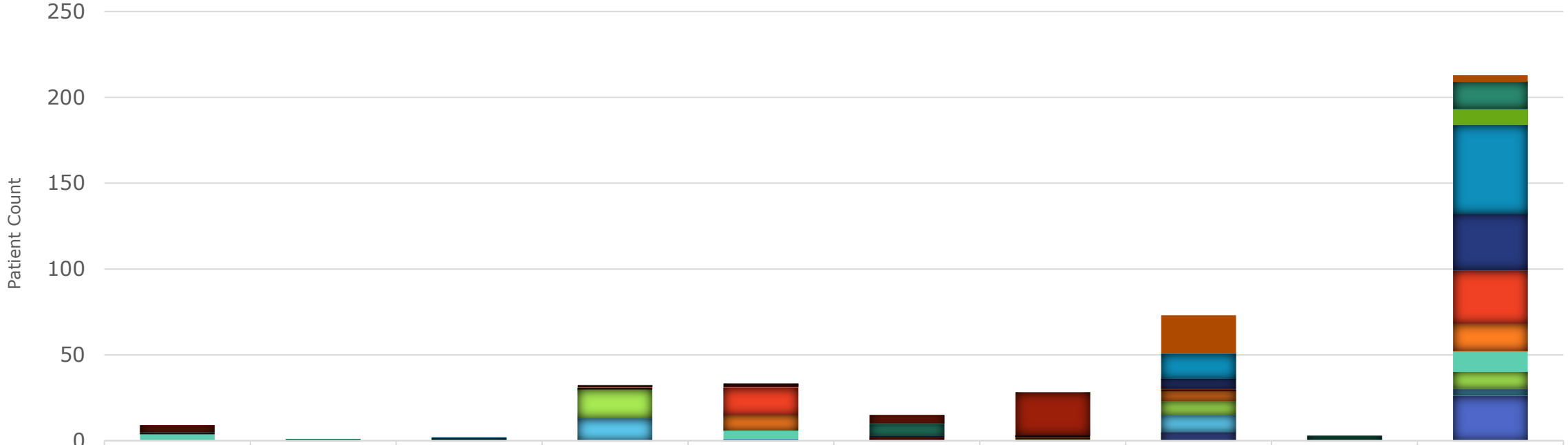
	KHS	KRH	MGH	UCD
VAMC- Send				3
MHS- Send			1	
MHF- Send			2	
KHS- Send			1	
KHN- Send	7	5		

2022-2Q Interfacility Transfers with Primary Impression of Stroke – EMS Data



	Air	KHN	KRH	MGH	MHS	MSJ	SMCS	UCD
VAMC- Send								1
UCD- Send		1						
SMCS- Send	1	2						
OOA- Send		1				1		
MSJ- Send		4	1					
MHS- Send				1		4		
MHF- Send			1	1		4		
KHS- Send		11		2	1			
KHR- Send		2				4		
Air- Send							1	

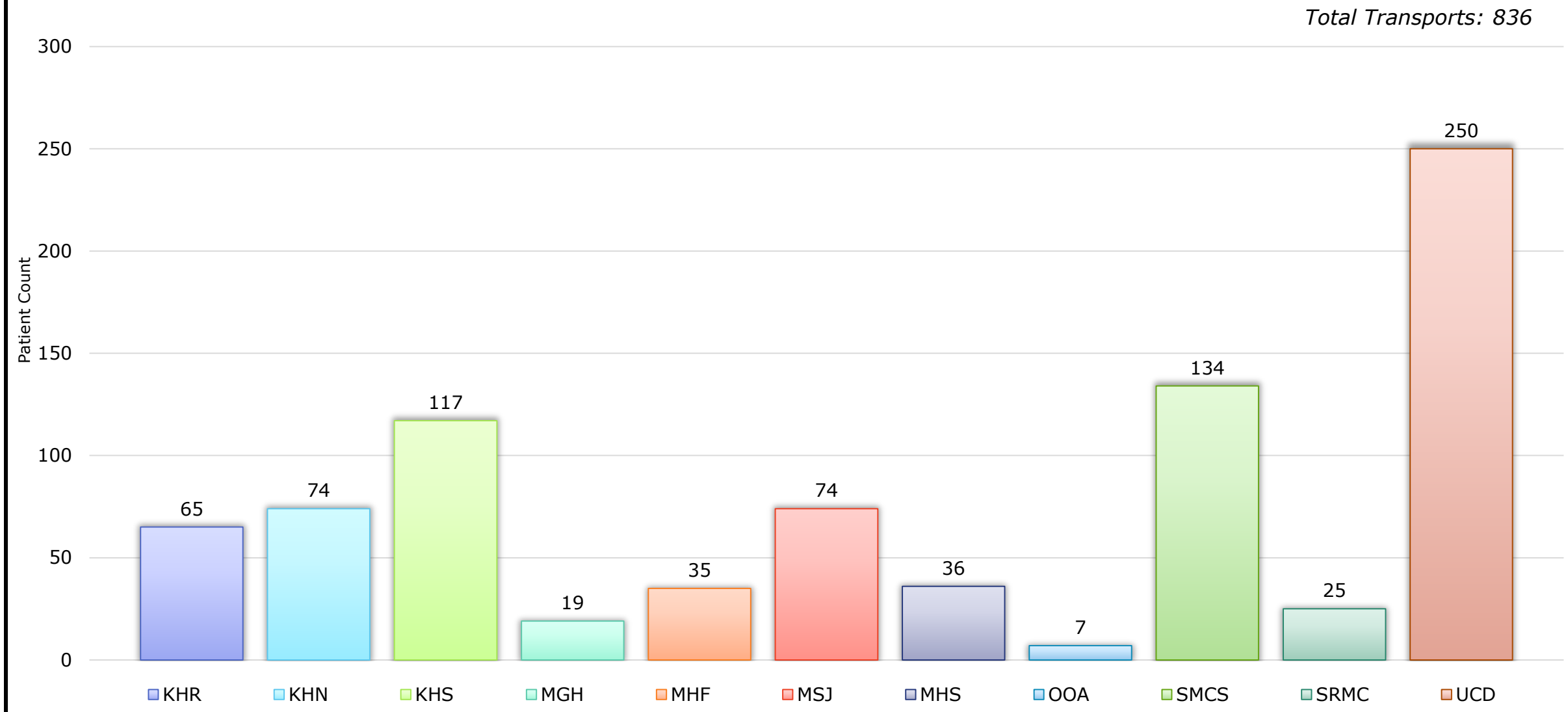
2022-2Q Interfacility Transfers Patients <15 Years Old - EMS Data



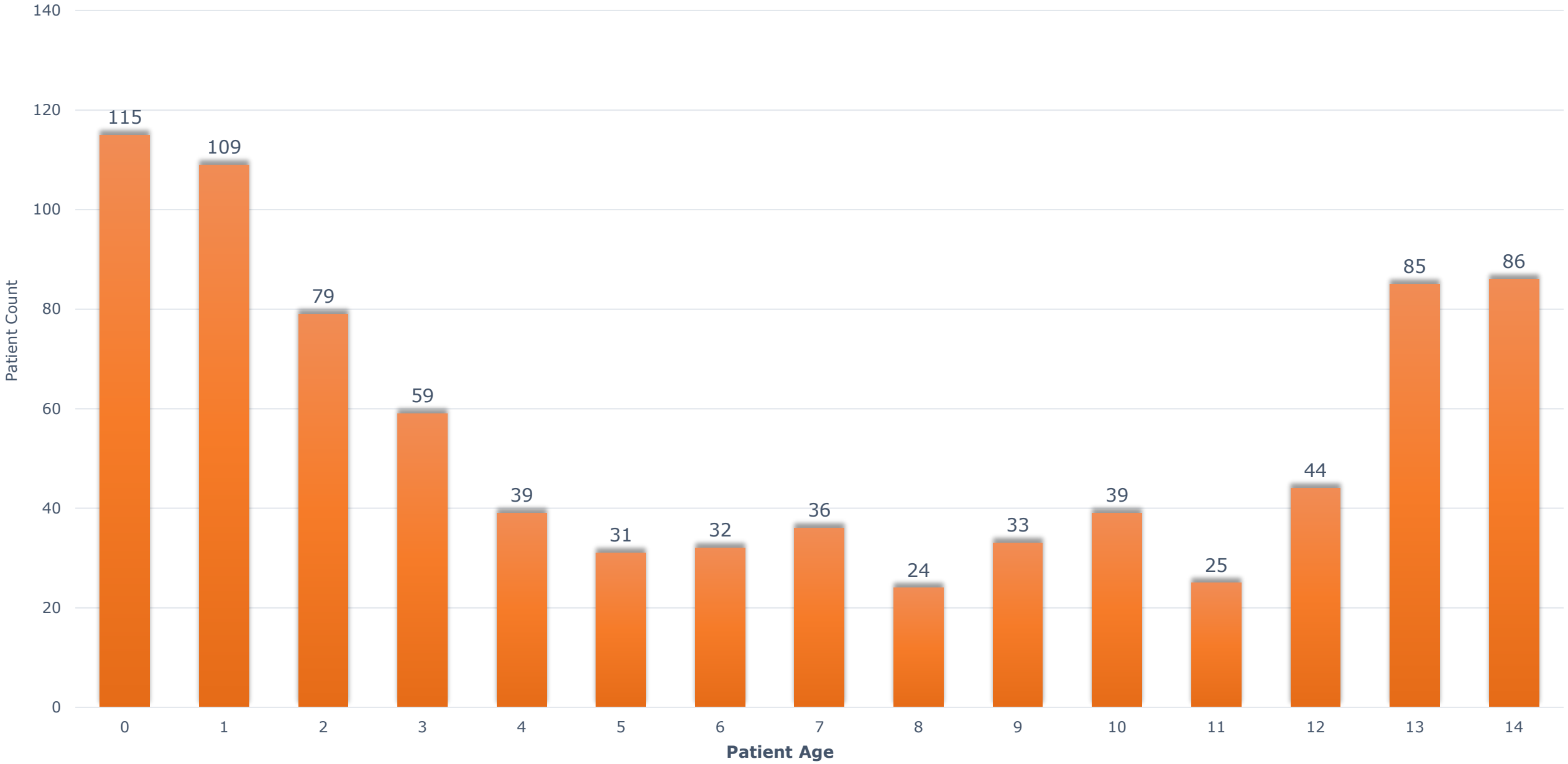
	Air	KHN	KHS	KRH	MSJ	OOA	Shriners	SMCS	SRMC	UCD
UCD- Send	4			1	2	5	25			
SRMC- Send								22		4
SMCS- Send	1	1				7			3	16
Shriners- Send										9
OOA- Send			2			1		15		52
MSJ- Send							1	6		33
MHS- Send				1	16	2		1		31
MHF- Send					9		1	6		16
MGH- Send	4				5					12
KHS- Send				17			1	8		10
KHN- Send				13	1			10		4
Air- Send								5		26

Pediatrics

Distribution of Scene Pediatric Patients to ED 2022-2Q - EMS Data



Count of 911 Response (Despite Outcome) per Patient Age <15
2022-2Q - EMS Data



Top 25 Primary Impressions for Transported Pediatric Patients 2022-2Q - EMS Data

Number	Primary Impression	Counts
1	Traumatic Injury	172
2	Seizure - Post	164
3	Behavioral/Psychiatric Crisis	50
4	Respiratory Distress/Other	45
5	General Weakness	36
6	No Medical Complaint	33
7	Fever	32
8	Nausea/Vomiting	32
9	Syncope/Near Syncope	29
10	Allergic Reaction	28
11	Overdose/Poisoning/Ingestion	26
12	Seizure - Active	23
13	Respiratory Distress/Bronchospasm	20
14	ALOC - (Not Hypoglycemia or Seizure)	17
15	Cold/Flu Symptom	17
16	Abdominal Pain/Problems (GI/GU)	13
17	Newborn	13
18	ALTE (BRUE)	11
19	Burn	8
20	Cardiac Arrest -Non-traumatic	8
21	Non-Traumatic Body Pain	8
22	Anaphylaxis	8
23	Airway Obstruction	4
24	Submersion/Drowning	3

STEMI

STEMI Dashboard - EMS Data

STEMI	System Total 2021 - 3Q	System Total 2021 – 4Q	System Total 2022- 1Q	System Total 2022- 2Q
Total transported patients with primary impression of STEMI	139	144	168	139
Total number of patients that received ASA or pertinent negative present	125	137	153	117
90% Scene time	0:31:41	0:16:26	0:16:59	00:16:52
Patient with eVitals.03 or eDevice.08 documenting ECG of STEMI (started monitoring 2022-1Q)	-	-	70	58
Percentage of STEMI primary impressions with a STEMI ECG	-	-	42%	42%
Patients with a pre-arrival notification (of STEMI ECG)	139	138	66	52
% Pre-arrival notification	100.00%	95.83%	94%	90%
90th % Time to First ECG (from arrival at scene to device)	0:14:33	0:20:00	-	-
90th % ECG to hospital notification	0:18:20	0:14:48	-	-

STEMI Core Measures - EMS Data

Core Measure	Definition	2021-3Q		2021-4Q		2022-1Q		2022-2Q	
		Patient Count	%	Patient Count	%	Patient Count	%	Patient Count	%
ACS-01	Number of patients 35 and older treated and transported to ED with a Primary (*or*) Secondary Impression of **STEMI** or **Chest Pain Suspected Cardiac** that received **ASA**	1,437	78.98%	1,532	70.89%	1,533	66.34%	1,527	70.99%
ACS-04	Number of patients with Primary (*or*) Secondary Impression of **STEMI** or ECG of STEMI - transported to a PCI capable hospital that had a STEMI alert	161	90.06%	197	82.74%	215	82.33%	183	85.79%
ACS-03	90th Percentile in **minutes** of Unit Arrived on Scene to Patient Arrived at Destination (Primary Impression of STEMI)	141	0:31	144	0:33	173	0:34	140	00:32:33
ACS-06	90th Percentile in **minutes** of Unit Arrived on Scene to First ECG (Primary Impression of STEMI)	141	0:14	144	0:14	173	0:13	140	00:14:22

STEMI Primary Impression for Treated and Transported Patients

Hospital Name	2021- 3Q	2021- 4Q	2022-1Q	2022-2Q
KHR	7	9	11	8
KHN	0	1	0	0
KHS	34	35	54	30
MHF	0	0	1	0
MGH	23	24	24	22
MSJ	41	38	43	35
SMCS	15	17	17	24
SRMC	6	3	7	5
UCD	13	17	11	13
Totals	**139**	**144**	**168**	**137**

CARES Data

No New Data

STROKE

Stroke Core Measure – EMS Data

Core Measure	Definition	2021- 3Q		2021- 4Q		2022- 1Q		2022-2Q	
		Patient Count	**%**	**Patient Count**	**%**	**Patient Count**	**%**	**Patient Count**	**%**
STR-01	Prehospital Screening for Stroke Patients	971	96.70%	900	95.00%	1,011	95.84%	993	95.67%
STR-02	Glucose Testing for Suspected Stroke Patients	971	94.95%	875	97.22%	860	96.60%	993	93.76%
STR-04	Advanced Hospital Notification for Stroke Patients with positive Stroke Scale	551	95.10%	584	94.00%	94.01%	602	600	93.33%

Stroke Dashboard - EMS Data

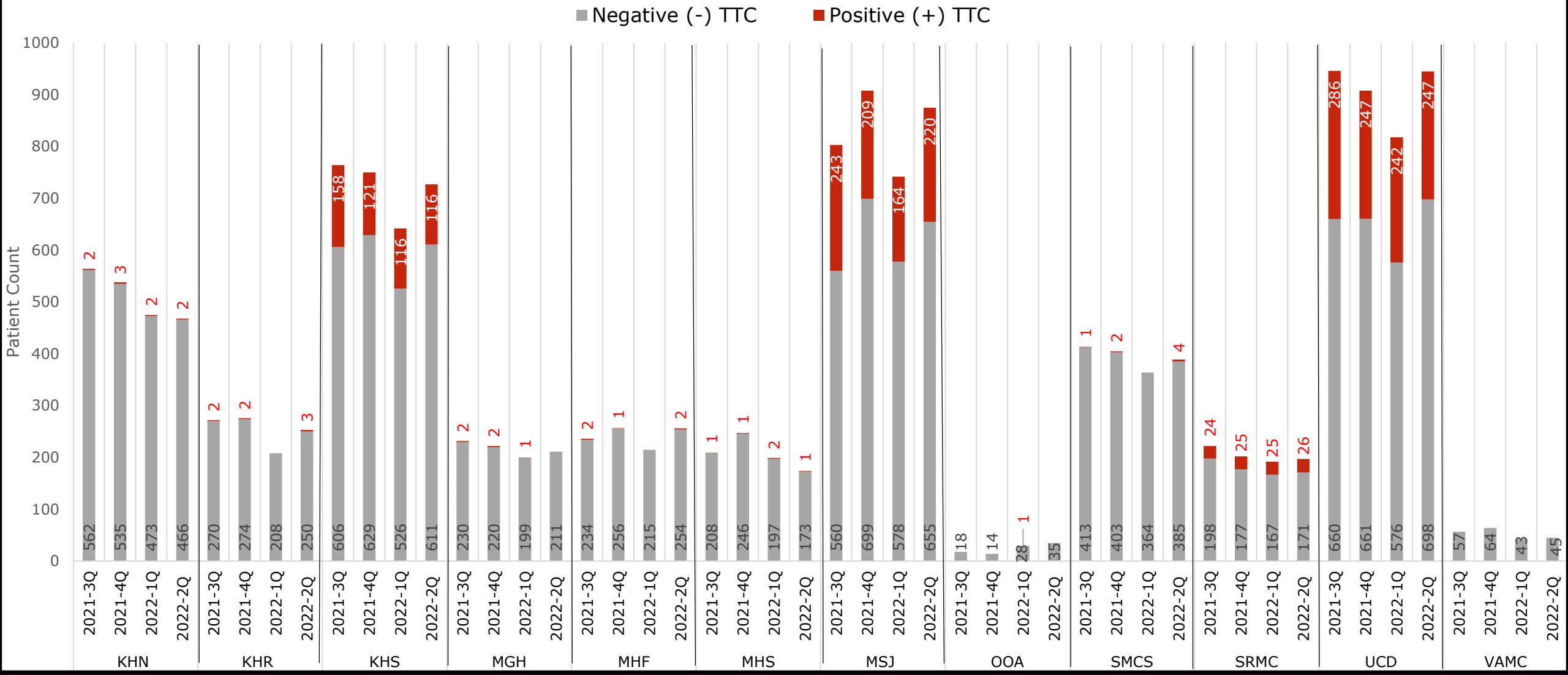
Stroke	System Total 2021- 3Q	System Total 2021- 4Q	System Total 2022- 1Q	System Total 2022-2Q
Total transported patients with Primary impression of Stroke	839	900	887	866
Number of patients with documented Stroke Screen	825	855	851	847
% of patients with documented Stroke Screen	98.33%	95.00%	95.94%	97.81%
Documented Glucose	816	875	860	865
% of documented Glucose	97.26%	97.22%	96.96%	99.88%
Patients with a Stroke pre-arrival notification	743	805	795	771
% of Stroke pre-arrival notification	88.56%	89.44%	89.63%	89.03%

Stroke Primary Impression for Treated and Transported Patients - EMS Data

Hospital Name	2021- 3Q	2021- 4Q	2022-1Q	2022-2Q
Kaiser Antioch	1	0	1	0
KHR	35	47	38	41
KHN	126	173	147	162
KHS	167	153	176	150
Lodi	1	0	1	0
MGH	48	37	42	38
MHF	41	66	72	45
MSJ	180	164	171	184
MHS	73	95	76	84
VAMC	2	0	0	
SMCS	75	76	81	74
SRMC	24	17	20	29
UCD	66	72	62	59
Total	**839**	**900**	**887**	**866**

Trauma

Transported Patients with a Primary Impression of Trauma per Quarter – EMS Data



Scene Time for Patients with +TTC 2022-2Q

90th Percentile - 00:15:00
Average - 00:10:39

13.58% of Trauma had +TTC
99.29% of patients with +TTC were taken to a trauma center

Emergency Medical Services (EMS) Agency
EMS Staffing Roadmap Updated / July 5, 2022

Brief Timeline

August 2, 2019 – Emergency Medical Advisory Group (EMAG) was created and began meeting. The group consists of EMS providers and health system leaders serving Sacramento County.

August 6, 2019 – Emergency Medical Services (EMS) presented a fee package to the Board of Supervisors. The letter addressed new programs and new and/or revised fees. One of the actions taken was to establish and maintain an advisory committee with stakeholder representatives to explore identification of potential sustainable sources of revenue, quality improvement and program planning.

October 8, 2020 – EMAG members discussed convening a work group to draft a letter regarding EMS funding and staffing to the Board of Supervisors. This work group drafted a paper that was presented at the December 10, 2020 and February 11, 2021 meetings.

February 9, 2021 – Brian Jensen, Hospital Council, presented the paper entitled, *Emergency Medical Services in Sacramento County: Solving the Budget and Staffing Shortfalls to Protect Public Health and Safety* on behalf of the EMAG work group. EMAG followed up with staff on February 11, 2021 requesting staff write a roadmap of staffing needs.

June 9, 2021 – Board of Supervisors approved two (2) of the EMS growth requests: Add one (1) EMS Coordinator to administer the Critical Care Programs, and add one (1) EMS Specialist II to develop and administer the Professional Standards program. The EMS space growth to relocate into a larger suite will be decided during the September budget hearing.

September 8, 2021: Board of Supervisors approved the EMS space growth request.

Public Health received funding for a Human Services Program Planner for the Department Emergency Preparedness program. EMS will supervise the position.

At the request of the EMAG, the following document outlines current staffing and future staffing needs in order to improve local EMS systems, including prehospital services and relevant hospital services such as trauma, stroke and heart attack.

June 8, 2022: Board of Supervisors approved to increase Medical Director's time to .75% and fund future contract with American Heart Association – Get with the Guidelines – Stroke and Coronary Artery Disease (CAD).

The EMS growth request: two (2) EMS Specialist – one (1) for Critical Care Programs and one (1) for Quality Improvement/Data will be decided during the September budget hearing.

Emergency Medical Services (EMS) Agency
EMS Staffing Roadmap Updated / July 5, 2022

EMS Current Staffing: FY 2022-23

Position	FTE	Overview of Responsibilities
EMS Administrator	1.0	Administers the EMS program and functions as the Medical/Health Operational Area Coordinator (MHOAC).
Medical Director (Contracted)	0.75	Provides medical oversight and direction of EMS programs, policies, procedures and quality improvement efforts. Facilitates the stakeholder EMS Committees.
EMS Coordinator	2.0	Administers the hospital critical care programs (STEMI-Cardiac, Stroke Critical Care Programs), functions as MHOAC and supervises EMS Specialists responsible for the following programs: ALS providers, QI, Trauma, and Training/Continuing Education. • 1.0 FTE EMS Coordinator approved in the FY 2021-22 budget, assigned to the Critical Care Programs. Hired September 12, 2021.
EMS Specialist Lv2	4.0	EMS Specialists administer specified programs: 1) ALS Providers, 2) Training/Education, 3) Quality Improvement/Data, and 4) Professional Standards. All assist in policy development/revision and complete investigations as assigned. • 1.0 FTE EMS Specialist II approved in the FY 2021-22 budget, assigned to the Professional Standards program. Hired September 12, 2021.
Human Services Program Planner	1.0	Develops and administers the DHS Emergency Preparedness Program, including; ensuring plans, policies and procedures are developed and maintained; describing operational roles and procedures; assessing employees' level of preparedness; representing DHS in county, regional or state planning; preparing and coordinating response within the department; and assisting with the coordination of the MHOAC and other departments and agencies involved in emergency preparedness. • 1.0 FTE Human Services Program Planner. Funded by Public Health and supervised by EMS. Hired October 10,2021
Administrative Services Officer II	1.0	Administrative functions such as budget, contracts, board letters, billing, online application system, and general administrative support.
Senior Office Assistant	1.0	Administrative functions including but not limited to reception, processing certifications/accreditations, processing payments, data entry and clerical support.
Total Staff	10.75	10.0 FTE County staff / .75 Contracted Medical Director • An increase of 3.0 FTEs.

As noted in the EMAG Briefing document, EMS is understaffed in comparison to other counties. Other comparable county EMS programs have more staff to manage the workload – Alameda County EMS (24 FTE), Santa Clara County (21 FTE), and Contra Costa County (15 FTE). While San Joaquin County is not comparable in size, the EMS Program has 10.3 FTE.

Emergency Medical Services (EMS) Agency
EMS Staffing Roadmap Updated / July 5, 2022

EMS Program & Staffing Needs

Statutory Function	Required / Permissive	Requested Position	FTE	Cost	Request Status	Rationale/Duties
Medical Oversight H&S Code 1797.202	Required – Partially meeting	Medical Director Increase contracted hours to full time incrementally.	0.75	$60,000	FY 2022-23	EMS is meeting the minimum level of medical control oversight. The proposed increase in hours is necessary to expand QI, policy/training review, compliance activities, and for program oversight: • Quality Improvement & data analysis • Training and education • Implementation of process changes based on data review.
		Total	0.5	$60,000		

Statutory Function	Required / Permissive	Requested Position	FTE	Cost	Request Status	Rationale/Duties
Quality Improvement/Data CCR, Title 22, Division 9, Chapter 12	Required – Partially meeting	EMS Specialist Lv2	1.0	$124,899	FY 2022-23	This position will be dedicated to: • Data reporting and analysis, which will enhance the mandatory QI program. • Analyze data for EMS Dispatch, Core Measures, Cardiac Arrest Registry to Enhance Survival (CARES), Critical Care programs (STEMI-Cardiac, Stroke and Trauma), and other indicators. • Identify trends, quality improvement measures, and implement process improvement as indicated by the Medical Director. • Cost for EMS Specialist, Step 5 ($109,899), plus $15,000 for furniture, ASD furniture and installation costs, and computer.
Critical Care Programs CCR, Title 22, Division 9, Chapters 7.1 & 7.2	Required – Partially meeting	EMS Specialist Lv2	1.0	$124,899	FY 2022-23	This position will be dedicated to: • Full implementation of the STEMI-Cardiac and Stroke Critical Care programs. • Cost for EMS Specialist, Step 5 ($109,899), plus $15,000 for furniture, ASD furniture and installation costs, and computer.

Basic Life Support (BLS) Provider H&S Code 1797.220 CCR, Division 9, Chapter 2	Required – Not meeting	EMS Specialist Lv2	1.0	$124,899	FY 2022-23	EMS does not have BLS program oversight or policies. Currently there are several agencies providing BLS services and some requesting to provide BLS services. This position will: • Develop and implement the new BLS ambulance provider program. • Conduct annual BLS vehicle and equipment inspections. • In addition to BLS, develop/update EMS Agency policies • Cost for EMS Specialist, Step 5 ($109,899), plus $15,000 for furniture, ASD furniture and installation costs, and computer.
		TOTAL	3.0	$374,697		

Statutory Function	Required / Permissive	Requested Position	FTE	Cost	Request Status	Rationale/Duties
Training & Education H&S Code 1797.214	Required – Partially meeting	EMS Coordinator	1.0	$154,586	Future	EMS does not offer all required training programs. This proposed new position will: • Oversee the existing Training Programs (EMT, Paramedic, MICN, EMR and Narcan), the CE Provider Program, and the new Public Education Program. • Develop policies and procedures for training programs. • Monitor compliance with policies and perform audits. • Investigate and respond to complaints regarding the training programs. • Cost: EMS Coordinator, Step 5 ($139,586), plus $15,000 for furniture, ASC furniture and installation costs and computer.
Training & Education H&S Code 1797.214	Required – Not meeting	Health Educator, Range B	1.0	$125,201	Future	The position will: • Coordinate and oversee evidence-based and quality improvement guided training and education of prehospital personnel, such as, Pediatric Advanced Life Support, Advanced Cardiac Life Support for prehospital personnel. • Coordinate, oversee and provide education/certification classes for EMT Training, First Aid, CPR, AED use for the public. (Public training is required but not currently offered.)

						• Cost: Health Educator, Range B, Step5 ($110,201), plus $15,000 for furniture, ASC furniture and installation costs and computer equipment.
Training & Education	Required – Partially meeting	Administrative Services Officer I	1.0	$121,174	Future	This position will offer necessary support for the training and education program. It will: • Be the primary contact for registration of education classes, coordinating the scheduling, collecting payments, coordinating classes. • Provide support to the Health Educator/EMS Coordinator positions. • Cost: ASO I, Step 5 ($106,174), plus $15,000 for furniture, ASC furniture and installation costs and computer.
		TOTAL	3.0	$400,961		

Statutory Function	Required / Permissive	Requested Position	FTE	Cost	Request Status	Rationale/Duties
Staff Support H&S Code, Division 2.5, et.al. CCR, Title 22, Division 9, et.al.	Required – *As program expands*	Sr. Office Assistant (Admin. Support)	1.0	$87,733	Future	This position will provide: • Clerical support to staff. • Public counter coverage. • Cost: Sr. Office Asst., Step 5 ($72,733), plus $15,000 for furniture, ASC furniture and installation costs and computer.
		TOTAL	1.0	$87,733		

Future Operational Needs	Requested Item (Function)	Annual Cost	Request Status	Rationale
Emergency Preparedness	Mobile Medical Shelter (MMS) Warehouse	$23,000	Future	Future lease cost for MMS warehouse. Estimated annual lease cost includes warehouse ($12,000) and exterior gated storage area ($11,000). *Currently, the warehouse lease ($12,000) is funded via County Office of Emergency Services for a (3) year period ending November 30, 2023.* • American Relief Funding requested.
Training & Education	Equipment & Supplies	$25,000	Future	If training and education programs are approved, there is approximately a one-time cost of $25,000 for equipment and supplies.
	TOTAL	$48,000		

Emergency Medical Services (EMS) Agency
EMS Staffing Roadmap Updated / July 5, 2022

Statutory Function	Required / Permissive	Requested Position	FTE	Cost	Request Status	Rationale/Duties
Community Paramedicine and Transport to Alternate Destinations Program H&S Code, Division 2.5, et.al. CCR, Title 22, Division 9, Chap. 5 et.al.	Permissive – New Regulations	EMS Specialist	1.0	$124,899	Future	EMS does not have a Community Paramedicine and Transport to Alternate Destinations program. This position will be dedicated to: • Develop and implement a Community Paramedicine and Transport to Alternate Destinations program • Cost for EMS Specialist, Step 5 ($109,899), plus $15,000 for furniture, ASD furniture and installation costs, and computer: • Conduct annual Community Paramedicine vehicle and equipment inspections.
		TOTAL	1.0	$124,899		

Areas for Future Exploration

During 2019 and recent stakeholder discussions, a few programs were briefly discussed and require more stakeholder/program review. These include the following:

- EMS for Children: This is an optional specialty program defined by the State EMSA and adopted by many counties. The goal of the program is to ensure that acutely ill and injured children have access to high quality, coordinated, and comprehensive emergency and critical care services appropriate for the special needs of children. This is a continuum of care beginning with the detection of sick or injured children and transport to the appropriate emergency department through rehabilitation. *Health & Safety Code, Chapter 12, Section 1799.202 et.al. and CA Code of Regulations, Title 22, Division 9, Chapter 14.*
- Critical Care Transport-Paramedic Program: This is an optional program that allows EMS providers to provide inter-facility critical care transport. These services provide a higher level of prehospital emergency care which reduces the impact on local emergency departments. *CA Code of Regulations, Title 22, Division 9, Chapter 4.*
- Electronic Patient Care Report (ePCR): During the Board of Supervisors Hearing in February, a board member asked if utilization of a single ePCR would help the hospital systems. Currently, there are seven different ePCR platforms. ePCR data submission is required in the H&S Code 1797.227. This item requires stakeholder discussion since public and private entities have invested in their individual ePCR platforms and would be a major change.
- Community Paramedicine and Transport to Alternate Destinations Program: This is an optional program that allows local EMS Agency to implement a program which allows EMS providers to assess and treat and/or transport patients to pre-approved alternate destinations rather than the emergency departments. These services will reduce the impact on local emergency departments. NEW REGUALTIONS: *CA Code of Regulations, Title 22, Division 9, Chapter 5*