Sacramento County
Department of Health and Human Services - Emergency Medical Services Agency (SCEMSA)
Joint Medical Advisory (MAC)/Operational Advisory (OAC) Committees
9616 Micron Ave. Suite 960
Sacramento, CA. 95827

September 9, 2021

Facilitator: Hernando Garzon, M.D. SCEMSA Medical Director
David Magnino, EMS Administrator

Scribe: Kristin Bianco, EMS Specialist II
Kathy Ivy, EMS Specialist II

Meeting Attendees: Attendees not captured from Zoom meeting.

September 9, 2021, Meeting Agenda can be located at:
https://dhs.saccounty.net/PRI/EMS/Documents/MAC%20OAC/2020%20Meetings/September%2013%2c%202020/September%2010%202020%20Agenda%20hg.pdf

Topic	Discussion	Action Item
Welcome and Introductions: 9:00 am	Attendees type names into the chatbox for attendance. Zoom attendees not captured.	
Public Comments: Dave Magnino	**Discussion of the EMS West Coast Memorial Ride.** • The Opening Ceremony will be on September 23, 2021, at the state capitol at 9:45 am.	
Agenda Review: Approval of Minutes-June 10, 2021	**Motion to approve:** David Buettner & Mark Piacentini	
Public Comment/Round Table	**Round Table:** Jeff Carl requesting the meaning of "Intrusion" in regards to trauma triage criteria. What are we using as a definition of a crumple zone and passenger space intrusion and how is it measured by crews in the field? Several incidents where medics are being subjective with 12-18 inches. • Dr. Garzon: The trauma triage criteria is 12-18 inches or more from intrusion.	

	• Kevin Mackey suggests that the question regarding the relevance of passenger space intrusion and how it should be measured by the field should be sent to the trauma community for guidance. • Dr. Rose points out that it is becoming a recurring problem of crews not giving an estimate of passenger space intrusion during their radio call-in. • Dr. Shatz has access to research papers done on the subject of intrusion done by researchers in Florida that he will pull and share with Dr. Garzon. • SCEMSA will look at creating a standardized training program for the ALS providers after more academic and data review along with a further discussion with the trauma community. • It was pointed out that the guidelines that are currently used are outdated and from CDC guidelines from 2011. • NTSB guidelines will be reviewed to help determine the current criteria suggested for Trauma Activations based on damage to the vehicle. • Dr. Garzon is going to reach out to the TRC, trauma centers, and surgical programs to work with them to make recommendations for trauma training standards in Sacramento. • Dr. Scarpa is requesting SCEMSA look into how many trauma patients are under triaged by paramedics and being transferred from a non-trauma center to a trauma center. • This is to be brought back to the next MAC/OAC meeting. • Dr. Beckerman will work with his trauma program to try to obtain the primary reason for the transfer of trauma patients to the trauma center. • The subject of under-triaged trauma patients will be taken to the TRC.	
Chairman's Report: • Vaccination Status for EMS Ride-Along • Current Covid Surge Data • APOT Report • Core Date Reports • Core Measures Report	**Vaccination Status for EMS Ride-Along** • Alpha one will accept negative COVID testing place of vaccinations for ride-a-long. • Wendin Gulbransen, Kaiser South, states all MICN ride-a-longs that come from Kaiser South will be vaccinated. • Jeff Carl, Mercy San Juan is requiring staff to be tested once to twice a week if they are not vaccinated. **CHAIRMAN REPORTS:** PowerPoint(s) attached to minutes.	

	Dr. Garzon met with Fire Chiefs and Hospital CEOs over dispositions of psychiatric holds and ED overcrowding. Wall-times and decompression hours: • June and July: up to 20-40 hours • August was severe enough that SCEMSA initiated an emergency ED diversion when three (3) or more ambulances were at a hospital for ninety (90) minutes or longer. • Since mid-August almost ten (10) hours of SCEMSA imposed diversion. **David Buettner:** LEMSA imposed decompression/diversion. How was this being monitored? **Dr. Garzon**: David Magnino and Ben Merin monitor the system. **Ben Merin**: Either Dave or I will get a call from an EMS Supervisor when a crew has been on the wall for ninety (90) minutes or longer. We confirm the supervisor is at the hospital of concern and get feedback on overall wall time status, how many ambulances, companies, etc. We get a full assessment of the system. We discuss with the charge nurse and if the system in question has no plan to decompress then we impose the diversion. If there is a plan then we do not put them on diversion at that time. **Dr. Garzon:** the majority of diversions are being self-imposed by the hospitals. I believe diversion is a poor choice to fix wall-times. **Brian Meader:** When SCEMSA calls the hospital and the hospital has a plan to off-load a gurney within an hour and a half and that ambulance has already been there for an hour and a half, the county is allowing the hospital to keep ambulances on the walls for two and a half hours. How is that acceptable? **Ben Merin:** The way regulatory and current contracts read, we don't have the authority to get them off the gurneys right away. How would you like us to fix it? **Brian Meader:** Policy 2524 is a start. We're allowing hospitals to treat while on the gurney and they shouldn't, they can't, the LEMSA doesn't have the authorization to allow that. **Ben Merin:** What you're suggesting is that you just stop treatment once in hospital for the patient that is sick? **Brian Meader:** What I'm suggesting is care stay with the practitioner who brought them in. **Ben Merin:** That is a discussion we can have internally then bring to MAC/OAC **Dr. Garzon:** Brian, we've traded emails back and forth on this and I have a meeting this afternoon with our legal counsel since you brought Medic's legal counsel into the email discussions. We will take this internally first then bring in the MAC/OAC. Policy 2524 is up in January 2022 but if we decide it needs to be reviewed sooner we will.	PowerPoints attached to minutes. In the go-forward assure labeling/abbreviations of hospitals (KHN, KHS, etc.) on graphs reflect the way they are in policies.

Pedi Dose Discussion- Dr. Nishijima **Old Business** • **PD# 2101** • **PD# 2305**	**David Magnino:** SCEMSA is not doing imposed diversion automatically. We work with the hospitals and providers first. **Dr. Garzon:** The only way we get through this crisis is if we work collaboratively with all service providers. COVID surge and staffing is the primary reason for long wall times, I don't believe treating or not treating a patient on the gurney will solve the long wall times. • Discussion regarding trauma triage criteria, over/undertriage by paramedics, and why some seemingly low acuity traumas are documented as "Trauma". **Dr. Garzon:** When looking to link ePCR to hospital data, when a transfer of care happens, can we or are we already, giving the patient hospital medical record number to the ALS provider so they can then document it in ePCR. Is that consistently being done? Yes- Sutter's, MSJ, and Kaisers **Barbara Law:** Which data element/field is being used? **Dr. Garzon:** e outcome 03 and e outcome 04. SCEMSA will communicate the guideline and recommendations. **Dr. Daniel Nishijima:** Emergency Medicine Physician at UCDMC and serves as an EMS Scientific advisor for the Pediatric Emergency Care network. Presented a new study called "Pedi-Dose" funded by the NIH, which studies/optimize seizure management in children. The study will start in Spring 2022. Sacramento City and Metro Fire Departments will be participating when launched. **Dr. Garzon:** Comparing how are we doing things now vs what will be different? Many of our providers use Handtevy for consistent pediatric dosing. As these roles are out we need to coordinate which providers will participate. SCEMSA will be very clear that if not part of the study you continue using the current SCEMSA policy. When is the anticipated launch of the study? **Dr. Nishijima:** Anticipate March-May 2022. It could be that early or it could be in 2026. We will have six (6) months of notification before it begins. **PD# 2101-**Patient Initiated Refusal of EMS Assessment, Treatment, and/or Transport: Hold to discuss this further to a meeting that was/is set up regarding the policy. **PD# 2305 –** EMS Patient Care Report: Completion, Distribution, and Submission: Approved at last meeting but brought back to show we did incorporate the edits. **APPROVED WITH EDITS.**	Dr. Nishijima to send PowerPoint to Committee

New Business Patient Release at Scene Discussion (Sundown Policy #2102) DEFERRED **PD# 2085** **PD# 8020** **PD# 8029** **PD# 8032** **PD# 8065** **PD# 9005 – SUNDOWN** **PD# 9007-NEW** **PD# 9008-NEW** **PD# 9011-NEW**	**PD# 2085 –** Do Not Resuscitate: The reason policy is out of turn. There was a case of a DNR patient being transferred from hospital to home for impending death per family wishes, and the patient expired enroute to the home, and it upset family and hospital because the crew went back to the hospital. We approached the coroner and that is why the language was added to direct EMS **not** to continue transport across county lines if the patient dies on the way home. **-Chief Law:** If the patient dies enroute, and they are a Kaiser Patient, should we proceed to their insurance group hospital or the closest? **-Dr. Garzon:** In-network. No reason to go to time-closest. -Add language to policy clarifying. -This only applies to patients with a DNR. If you're starting CPR then it does not fit in this policy. **PD# 8020-** Respiratory Distress – Airway Management-Respiratory Failure: Brought here early due to the QI TAG Committee adding a NOTE to policy. – **APPROVED with EDITS** **PD# 8029-** Hazardous Materials: Removed a no longer existing cross-reference. – **APPROVED with EDITS** **PD 8032-** Traumatic Cardiac Arrest (NEW): Created to help call out the differences between medical and traumatic cardiac arrest. • No role for Epinephrine in cardiac arrest secondary to trauma. • Not a stay and play, it's a load and go. • Fluid and hemorrhage control is the key • Amiodarone is rare in cardiac arrest. If I saw a rhythm that required amiodarone then run it as a medical cardiac arrest. • Removed the 20 minutes on scene -**John Rose:** Confusion still exist with the termination of resuscitation language. Discussion around the twenty-minute (20) language. **-Dr. Garzon:** should we remove the TOR language? **-Chief Law:** Yes. At the top maybe the policy should explain, why epinephrine is not a requirement in traumatic arrest. **-Dr. Garzon:** This is education. Protocol E. to make a point that there is no role for epinephrine in traumatic epinephrine with an explanation. Once standard practice then removes it. -**Chief Law:** In letter, A. should medics try to differentiate medical vs. traumatic arrest? -**John Rose**: E and C are perfect I would put A later because B and C are the crust of this protocol and D looks at the same as B and C.	PD# 2085-Incorporate Chief Law's comments into policy. Add clarifying language about staying in the network

	-**Dr. Shatz:** 14-15% rate of traumatic arrests that were medical is what we are seeing for the Sacramento area. It's pretty obvious that medical is a medical vs. a trauma. **-Dr. Garzon:** We will make B, A, and add a letter E with an explanation for epinephrine, make A the last letter in the protocol and reword it for clarity. Condense D into B and C. Will bring it back to the next meeting. **-Chief Law:** Rapid decision point should be mentioned at the beginning of policy vs. end. Can we have this effective sooner than July 2022? **-Dr. Garzon:** If the committee would like this implemented sooner if crews can be trained up faster. January 1, 2022, after December, meeting-make it effective. -Greg Markell: Algorithm would be very helpful for this policy. Dr. Garzon: I agree. **TABLED until DECEMBER** **PD# 8065-**Hemmorage: Pulled out of turn for the tourniquet update. -Chief Law: Question regarding TXA inclusion criteria. -Dr. Garzon: Clarity on the blood pressure. My understanding is indication is for signs of shock. Besides B/P of less than 90, it can also be blue lips, LOC, sweating, shallow breathing, dizziness, etc. -Dr. Shatz: B/P is the most objective sign of hemorrhagic shock. Most of the literature is consistent with this too. -Chief Law: the question we get from medics is; does the B/P have to be less than 90 for it to be a standing order? -Dr. Shatz: It truly is the most objective sign. If we start adding more criteria it gets misinterpreted We are trying to be specific to patients that actually need it. -Dr. Garzon: How would it be if we put it: B/P less than 90 OR other signs and symptoms of hemorrhagic shock? -Dr. Shatz: I'm okay with that but we will need to track it. It will need to be well documented for the "other signs and symptoms". -Chief Law: Dr. Shatz what I'm hearing is that the best indication is the B/P should be less than 90 but that isn't clear in the policy the way it's written right now. How about; signs and symptoms of hemorrhagic shock AND SPB less than 90. -Kevin Mackey: Just want to cautious us from straying too far from what the literature has already told us. -Dr. Garzon: Make it simple and make it with SBP less than 90. **APPROVED with EDITS**	

	PD# 9007-Pediatric Diabetic Emergencies (NEW):9005 – Pediatric Decreased Sensorium will be sun-downed and replaced with three (3) separate policies. A comment regarding determination for blood glucose: it is initially in BLS section, so not repeated in ALS. It states: for a blood sugar less than 60. We need the option to deliver dextrose/glucose in another form. My suggestion for change is: If blood glucose less than 60 and patient does not tolerate oral glucose then: (dextrose bullet points of options). -Chief Law: Yes I thought it was repetitive. -Dr. Garzon: SCEMSA will clean up # 3 and 4. -Chief Law: what are options are for first attempt? When do you want medics going to IO? It's mentioned it in the first step then in notes it states if Glucagon IM doesn't work then go to IO. -Dr. Garzon: Our vascular access policy, states the indication for IO. It's escalating, as a secondary form of access. Moved to quickly in (pending) /cardiac arrest. We give the routes without indicating the preferences. We leave that to providers for education. -Dave Sac Metro Fire: Concentration of D50 can be used? Are we excluding D25? In note section it states specifically D50 or D10. -Dr. Garzon: we will add D25 to the policy. Also change the Invitatory list to include it. – **APPROVED** with EDITS **but BRING BACK** in December for final review. **PD# 9008-**Pediatric Seizures (NEW): Dr. Garzon: Looking at the comments: clarifying the circumstances that require a Base Hospital order, because as its currently written it's not clear what "other indications" are since they are not listed. #7 is the indication, "continuous seizure". Do we eliminate Base Hospital? Per Dr. Nishijima IM/IN are the preferred routes. SCEMSA will change the order placing IV last- **APPROVED** with EDITS. **BRING BACK** IN DECEMBER FOR REVIEW **PD# 9011-**Pediatric Overdose: Now includes all possible overdoses. One comment under the ALS section was to change the B/P language to: Titrating appropriately to age. We will make adjustment. Another comment that we should include CPS notification. I think we can make that comment about every pediatric policy we have. This may be a training issue versus putting it in all policy. -Chief Law: we've had a number of cases where it should have raised a red flag that we have caught on back end. Does UC Davis have any comments on this? -Dr. Rose: we don't have the pediatric facility with me today but I will ask if that would be helpful. -Dr. Garzon: ED staff is usually pretty in tune to this. I think it's a valid question then the next question is what policies does this belong in, or should this just be rolled out as a mass training issue.	

Scheduled Updates: **PD# 2007** **PD# 2010** **PD# 2020** **PD# 2026** **PD# 2500** **PD# 2510** **PD# 2520** **PD# 4003** **PD# 4050** **PD# 4055** **PD# 4302** **PD# 4303** **PD# 9006** **PD# 9009**	-Chief Law: We participate on the County Child Death Review Team, and this has been commented on more than once. They have seen delays in notifications at all, sometimes a couple days into an issue before they are notified. -SCEMSA staff: how do we encompass everything that should require a notification? Elder, domestic, child violence. -Comment: I agree this is a training issue, it is state law for mandatory EMS reporting. -Dr. Garzon: SCEMSA will hold off on putting this in policies, but we will follow up on how to get info out there, whether we put out a CE course or providers. -Chief Law: Seizure protocol, adding in temperature check/cooling measures. -Dr. Garzon: We will add that to the BLS section of the policy. – **APPROVED** with EDITs/ **BRING BACK** IN DECEMBER. **PD# 2007-**Trauma Hospital Data Elements: SCEMSA went through the NTDB dictionary and assure elements and language is consistent. It was reviewed by TRC and no changes were recommended. **APPROVED** as written. **PD# 2010-**Medical Advisory Committee: Language cleanup only. **APPROVED** as written. **PD# 2020-** Operational Advisory Committee: Language cleanup. **APPROVED** as written. **PD# 2026-**Trauma Review Committee: Language cleanup. **APPROVED** as written. -Dr. Garzon: One comment we had about the MAC/OAC and TRC was voting. Policy has a statement in it that says: while this is an advisory committee, at the discretion of the chair, there may be a vote. The comment was who has the right to vote? Good question, so what we need to do with the policies is outline the membership as we do with MAC/OAC, and the voting rights are to designated members who are on our active committee members list. Add into committees. **PD# 2500**- EMS Aircraft Designation Requirements: Language cleanup. **APPROVED** as written. **PD# 2510-** Designation Requirements for Ground Based Advanced Life Support (ALS) Service Providers: ALS acronym spelled out. **APPROVED** as written. **PD# 2520**-Hospital Emergency Service Downgrade: Minor language cleanup. **APPROVED** as written. **PD# 4003**- Emergency Medical Services Liaison Officer: -Ben Merin: I've found over the last couple of years, due to COVID, we've lost the intent of this policy. I have five (5) contacts at Sutter, five (5) at other agencies, everyone reaches out asking questions and we answer the questions but I believe it's time to get back to its intent. -Dr. Garzon: Are we looking for one (1) point of contact and depend on them to spread the word?	Follow-up on mandatory EMS reporting for Child/Elder/Domestic Violence CE courses.

	-Ben Merin: Yes, one example is the newly SCEMSA imposed diversion. We distributed it our contacts and it didn't get to their administration. I want everyone away I want to start pushing to get back in line with this policy, so communications aren't missed. Designate one person that will communicate with their agency. -Dr. Garzon: Just to emphasize on this policy, if you are the designated ELO for your agency it is your responsibility to communicate all relevant EMS activity to your chain of leadership. -Nate Beckerman: Policy A directly talks about out of hospital providers not hospitals. Is this going to be expanded to apply to hospitals too? -Ben Merin: I believe it should be. C brings in Hospitals. I think this should be a SCEMSA internal discussion, then bring back to MAC/OAC. -David Buettner: That discussion should include all the avenues the LEMSA communicates to, i.e. prehospital coordinators, executives, doctors etc. It probably should define what the ELO Is responsible for at each of the hospitals. **-BRING BACK** in December. **PD# 4050**- Certification/Accreditation Review Process: -Brian Pedro: In the procedure section Letter B. You have the authority there but below its EMSA. -SCEMSA: Corrected. Suggested edits were made to the policy. **APPROVED** with edits. -Chief Law: does this apply to MICNs? -Dr. Garzon: SCEMSA certifies MICNs, we don't have the authority against their license, just their certification. **APPROVED** with edits. **PD# 4055**-Criminal Background Checks: Language edits. **APPROVED** as written. **PD# 4302**- Continuing Education Provider: Language cleanup. **APPROVED** as written. **PD# 4303**- EMR Training Program Requirements and Approval Process: No changes to policy. **APPROVED** as written. **PD# 9005**-Pediatric Decreased Sensorium: Sun setting. **PD# 9006**- Pediatric Cardiac Arrest: Small language changes. **APPROVED** as written. **PD# 9009**- Pediatric Neonatal Resuscitation: No changes by SCEMSA. **APPROVED** as written. **PD# 9010**-Pedicatric Overdose and/or Poison Ingestion: Sun setting.	SCEMSA to discuss internally and bring back in December.
Round Table:	-Dr. Garzon: reminder. 12-lead EKGs are supposed to be left at facility, shown to staff and attached to ePCR. We've had a number of concerns about ER nurses contacting medics on their personal cells advising them of impact and avoiding said ER. That type of direct communication is not appropriate or acceptable.	

	-Jeff Carl: Please let us know if that occurs so we can address it immediately. -Dr. Garzon: Yes we will forward it if we get a complaint. -Chief Law: I have a general question, I know we have the wall time committee, I was curious if value in adding members from SSV hospitals because we don't have the perspective yet. I believe it would be beneficial and possibly ALS provider also. -Ben Merin: to make changes to that particular group, the suggested change would have to be run through the EMAG. -Dr. Garzon: I can bring it to the EMAG group because I do believe it would be beneficial. - Sutter Roseville ED director: SSV has an APOT committee and we've made significant changes over the last year. I would be happy to join for the SSV side. -Wendin Gulbransen, Kaiser South: promoting run review September 21. Virtual opportunity. Trauma and toxicology discussions. -Dave Shatz: in the last year we've gotten 36 patients who have only received Ketamine as an only analgesic in trauma patients. Many of them have been so altered and when Ketamine wears off they have been perfectly normal. 75% of those cases are from Sac City Fire. When this was the discussion at EMDAC it was all about opiate addiction but I don't think we're going to create an addict by giving a single dose of Fentanyl. I don't think Ketamine is the right drug for initial pain relief. Medics even document "patient became altered" that's because they gave it too fast. -Jen Denno: we've had the same issue, approx. 8 cases and had to work them up as strokes because they were so altered. -Dave Shatz: we need to rethink the Ketamine policy. -Dr. Garzon: thank you both, I did receive a couple of emails from one of our facilities regarding this. I think it's a new drug. I asked all hospitals to relay any cases that came in that way. I did run the use of Ketamine and opiates. I was surprised by how much Ketamine was used. I do agree this deserves a review to either eliminate Ketamine or put it as a third option. Anyone want to defend Ketamine? -Julie Carrington: I do. We were seeing that early on, and we recognized that the ability to control the drip was scattered. Remember we went from 5 minutes to 10. Are they giving it over the 5 minutes or then new 10 minutes and how are they giving it and assuring the drip rate? I don't want to see it go away. I think training is needed. -Jen Denno: we aren't sure how it was administered but one patient got it for hip pain and we missed a small bowel obstruction because she was so altered.	

	-Dr. Mackey: Hernando you know in Mountain Valley that's where we started the Ketamine study and Riverside county and our county studied Ketamine the most. This is 100% a training issue. Ketamine in the appropriate setting and administered appropriately is extremely beneficial drug. -Dr. Garzon: I agree. Let's discuss off line. I would like hospitals to forward these cases to SCEMSA and the provider. QI is about follow-up, review and revisions as needed.	
Adjournment:	Adjournment: 12:30 PM	

Next MAC/OAC Meeting: September 9, 2021