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

December 15, 2020

Facilitator: Hernando Garzon, M.D. SCEMSA Medical Director
David Magnino, EMS Administrator
Scribe: Kristin Bianco, EMS Specialist II

Meeting Attendees:

Agency:	Representative:	Agency:	Representative:
Mercy San Juan/American River College/AlphaOne Ambulance	Nathan Beckerman, MD	Sacramento City Fire Department	Brian Pedro
UC Davis Medical Center (UCDMC)	John Rose, MD	Sacramento City Fire Department	Rob Walters
American Medical Response	Jack Wood, DO	Folsom City Fire	Mark Piacentini
Fire and Rescue Training Authority	Cristy Jorgensen	Mercy General/Methodist	Dave Haller
AlphaOne Ambulance	Matthew Burruel	TLC EMS Ambulance	Sean Pfeifer
Cosumnes Fire District	Jim Bugai	American Medical Response	Dennis Carter
Cosumnes Fire District	Julie Carrington, RN	Medic Ambulance	Mark Mendenhall
American Medical Response	Daniel Iniquez	Norcal Ambulance	Anthony Gallardo
Norcal Ambulance	Anastasia Pieda	Sutter Health Hospital, Sacramento	Jen Denno
Mercy San Juan	Paula Green, RN	Sacramento Metropolitan Fire Department	Barbara Law
Sutter Sacramento Medical Center	Karen Scarpa, M.D.	Sacramento Metropolitan Fire Department	Brian Benton
Life Assist	Becky Rowe	Sacramento Metropolitan Fire Department	David Sutton
Sutter Roseville Medical Center	Debbie Madding, RN	Sacramento Metropolitan Fire Department	Cindy Hamilton
Portola	Troy Biell	Sacramento Metropolitan Fire Department	Ben Cargile
SCEMSA	Dr. Hernando Garzon, EMS Medical Director	SCEMSA	David Magnino, EMS Administrator
SCEMSA	Ben Merin, EMS Coordinator	SCEMSA	Dorthy Rodriguez
SCEMSA	Kathy Ivy	SCEMSA	Kristin Bianco
UC Davis Medical Center (UCDMC)	David Buettner, RN		

December 15, 2020 Meeting Agenda can be located at:
https://dhs.saccounty.net/PRI/EMS/Pages/Committees/MAC-OAC/MAC-OAC%20Meeting%20in%202021/March%2011%2c%202021/March-11%2c-2021-MACOAC.aspx

Topic	Discussion	Action Item
Welcome and Introductions: 9:00 am	Room introductions are noted in the attendee list.	
Public Comments: None	None	
Agenda Review: Approval of Minutes- September 10, 2020	Motion to approve: David Buettner and Karen Scirpa	Approved as written
Chairman's Report: APOT Report Core Measures Report IFT Report Quality Improvement Update Dashboards	Dr. Garzon: On the Chairman's Report, Dave Magnino would like to mention the Fees for 2021, and 2022 are available for review and have been posted on the website. **Dr. Garzon:** **APOT Report:** These are numbers for the APOT one and two going back from December of 2019 through November 2020. The reports are separated by the facility. These can always be better but I am somewhat relieved that if you notice back in August, we have a huge bubble and I was concerned when we were seeing winter level wall times in the middle of Summer. They have gone up a bit in the last month or two, but they are not as bad as August. Things are getting more impacted. **Core Measures Report**: The core measures report for 2019 has been de-identified so you don't see agency names. We are significantly in the red with all of these core measures. At this point, I believe we are beyond a quality documentation initiative. I have said this before and I will repeat this, , at this point I believe we are beyond a quality document initiative. It has been more than two years since we went to a mandatory Electronic Health Care record and we have been working on QI. Realizing the variety of documentation practices, and different EPCR platforms, we realize that upfront initially when we started looking at this, there were significant variations in the documentation. After more than two years of working on documentation, at this point I am considering that if you didn't document it, you didn't do it. It is time to start calling ourselves out on our documentation and to say this is a reflection of our practice in the field. This is the way the State is looking at these numbers when the go out nationally, and this is how Sacramento and California are going to look. An example is, if this says you are only giving 60% of your chest pains Aspirin, then I am going to hold you accountable. I think we need to improve these numbers significantly. Dorthy sent out every individual agency's number in comparison to the SCEMSA averages so you can compare. So the SCEMSA averages, in general, are still all in red. If you are above the SCEMSA average, don't pat yourself on the back too much if you are still red. I think we need to work on improving this significantly.	PowerPoints attached to minutes

	IFT Report: A quick view of total Inter-Facility Transfers (IFT). The blue is 2019 the orange is 2020, there is significantly more across the board. **Dr. Garzon:** Moving on towards the COVID related data. We started looking at this when the first wave happened. This is looking at the five respiratory Primary Impressions that could be related to COVID. You can see when we went to 2020, the current year is in blue by comparison to the green when we went to the 'stay at home' order in April. We have a significant drop in Influenza-like illness (ILI) but also all EMS volume. When we got the case jump in June and July, you can see how the blue line went above the green and then leveled off. Concerningly you can see the most recent blue line is up. That is consistent with increased ILI numbers in emergency departments and patients being admitted. I think our overall EMS call volume is about the same. You can see from the graph the percentage of ILI type symptoms is up. The last thing on the Chairman's report is the COVID update. Things look bad everywhere. I am doing everything I can to sound the 'fire alarm' with the Governor and the Secretary of Health with the Public Health work I am doing. There were 50,000 positive cases reported yesterday. I have been tracking the hospital reports. They are up to 3,000 yesterday. About three weeks ago, we were about 600 COVID hospitalizations statewide, yet yesterday we broke the 3,000 number. We have been running 2,500-2,600 for about four or five days. We have been going up a couple hundred about every 3 days. We had a 15% increase or about 400 patients up to 3,000 admissions statewide yesterday. Southern California and San Joaquin County are the most affected. The greater Sacramento area is as well. One of the challenges for Sacramento is that we have relatively little headroom for ICU beds to begin with. Other counties throughout the state have 40% ICU availability on an average day whereas Sacramento usually has somewhere between 20% and 23%. The 'Stay at Home Order' is triggered by an ICU bed availability of less than 15%. San Joaquin and Southern California met that on December 6, 2020. Greater Sacramento met that on December 10, 2020. So, we have a stay at home order. All restaurants were to be closed on December 10, 2020. The other thing that we track is mobility data. One of the things the data tracks is time away from home on cell phones. You can see with the first wave of COVID and the first stay at home order. You can see it is very useful and interesting data. This data showed a significant drop. People went down to around 20% of their time away from home with the first stay at home order. That has not happened with this stay at home order in the last couple of days, by comparison, people are only about 70%-80% stay at home. As the cases continue, 12% of them turn into hospitalization two weeks later. That is my analysis of my review since April. I think we are likely to exceed our ICU capacity and may brim or exceed hospital capacity. Sleep Train Arena is open. They have accepted thirteen transfers in the last two days. One from Los Angeles, one from Orange County, and the other eleven from Sacramento County. Some of	

	our hospitals have started to offload their patients. These alternate care sites are step down care. They do not take care of critical patients. The patients have to be able to manage on four liters of oxygen or less, be a one-person assist, mild dementia is ok, but severe dementia has certain limitations in caring for those patients. So they can only offload to some extent. I am working on the mental health issue and trying to offload mental health patients from Emergency Departments, but that is an uphill battle. Before we get to policies, I would like to open it up in the chat for people to make comments specifically around COVID. It is worth addressing in this public forum what your experiences and troubles are. **David Buettner:** Do you have a suggested strategy for the quality of documentation and where do we go next, but we can talk about that later. **Dr. Garzon:** We will address that in the TAG meeting this afternoon. **David Buettner:** All of the providers are doing a good job of responding to hospital concerns about PPE with masks in place when they arrive. If we contact a provider about a crew not having a mask or on a patient etc., we are getting good responses from the providers and they are giving feedback to their crews. It is a long-standing Pandemic. We are nine months into this now. It should be everybody's first go to after putting their seatbelt on in the ambulance, they should be putting their PPE on as well. We are getting good responses from the providers and I want to thank everyone for that. **Dr. Garzon:** I would like to mention that we still get occasional one-off complaints from the public. We have had some complaints from elderly folks who see EMS staff or Firefighters in supermarkets not wearing masks. The complaints seem to come because of the occasional response "we are not required to wear masks." In the EMS community we should be setting an example for the public and following the mandatory masking guidelines. **Dr. Scarpa:** Sleep train is not very helpful. Is there any way to increase their criteria for acceptance? **Dr. Garzon:** I think there are many challenges in being able to use those facilities for sicker patients. They did try to open it up to skilled nursing facility patients. I don't think we can look to the Alternative Care Sites (ACS) to provide significant offload for patient volume. Here in Sacramento County, even though they may have 200 beds, we have nine hospitals. I think it is going to be getting one or two occasionally out of your facility for the near future. **Dr. Beckerman:** I'm not sure if you're aware, but last I heard, Heritage Oaks had set up a COVID area. This may help the mental health issue if psych patients are stuck in the ED because they are COVID positive. **Dr. Garzon:** I believe our psych ED staff are probably aware of this.	

	The one other thing that I would mention, related to COVID is that in the next couple of days I will review and issue updates regarding policy 5200. There are a couple of key things about that policy. One is that we are at the point that we need to consider everyone as a potential COVID positive patient even if they do not have a fever or cough. The transmission rate is so high in the community; someone could have a sprained ankle, no symptoms, and be COVID positive. I think we should simplify dispatch questioning, and I think from the EMS side we need to be masked with N95's, have eye protection, gloves, and gown use for aerosol-generating procedures, and presume every patient is COVID positive. That would simplify the approach to all patients and we would be COVID ready for all patients. In terms of testing, If you have an exposure we will do a slight variation of what we are doing now in policy 5200. I will put it out there for review and get feedback before we finalize it. One of the challenges that I'm having at the state level is trying to get a sense of how much ICU space can surge up. I would like to get a sense of your experience if you happen to know. We are tracking the number of staffed ICU beds that hospitals are reporting, but there is no good measure of how much they can surge up. We know that the biggest problem is staffing. We seem to have bed spaces and plenty of ventilators, but staffing is a huge issue. One of the things that went into place last Friday is that hospitals who are requesting a staffing waiver can consider it immediately in effect before review and final approval. The staffing waiver allows ICU's to go from one to one, to one to three. Theoretically, with the waiver, ICU's can increase their open beds by double. Realistically I don't think that happens, some patients require one on one care even with the waiver that authorizes two to one. Realistically what do you think your ICU's can surge up to would be the only question that I have. In reviewing hospitals that have received staffing waivers in the last four weeks, it doesn't look like their ICU open bed availability goes up by much. I'm curious as to what you feel on the hospital side what your ability is to ramp up ICU's. If you have other thoughts or questions about COVID, please feel free to email me.	
Supplemental Old Business: • PD# 8020-Respiratory Distress-Airway Management-Respiratory Failure	**Old Business Policies/Protocols:** **PD# 8020-Respiratory Distress-Airway Management-Respiratory Failure:** The changes to this policy is to eliminate King Tubes. The supraglottic airway device of use will be the Igel. This will take effect July 1, 2021. You have until July 1, 2021, to transition over. The other thing that we did was to add the cross-reference of PD# 8829 Non-Invasive Ventilations. **APPROVED**	

• PD# 8027-Nerve Agent Treatment (Combined Policy) • PD# 8062- Behavioral Crisis-Restraint • PD# 8830-Supraglottic Airway (iGel) • Ketamine for psychiatric and behavioral emergencies.	**PD# 8027-Nerve Agent Treatment:** We combined the Mark-1 and the DuoDote policy into one. The reason Mark-1's are still on here is that there are still some of them in the field. The indications for these two are the same, that is the reason the policies were combined. **APPROVED** **PD# 8062-Behavioral Crisis-Restraint:** This policy is tabled until we can talk to law enforcement and get them involved in the discussion. We need to sort out that for combative patients, law enforcement will accompany the crew to the ED. This will require a meeting with law enforcement so we can have a collaborative agreed-upon policy. Dave Magnino would like this policy tabled until we can have those conversations with law enforcement. **TABLED UNTIL MARCH 2021** **Dave Buettner:** I am wondering if before we attempt to sit down with law enforcement, we might want to consider surveying the providers to get impressions of how they interact with law enforcement, what the responsiveness has been in the past, and if there is or is not an issue with having law enforcement at these behavioral crisis calls. **Dr. Garzon:** I think that is a good idea. We would have to separate one-off cases where there is a disagreement between law enforcement and EMS versus if there is a reoccurring pattern of problems. **PD# 8830-Supraglottic Airway (iGel):** Based on our research, the counties that are currently using iGels in pediatric patients are Yolo, SSV, and San Joaquin. On this policy, we added a reference to respiratory distress that allows the use of supraglottic airways down to age 8. For EMT's we are adding the supraglottic airway option for cardiac arrest age 15 years old or older. **Jack Wood:** Is there a reason there is an age difference or did it have to do with scope of practice? **Dr. Garzon:** For the EMT's Jack? **Jack Wood:** Correct. for Paramedics it is the age of 8 and for EMT's it is the age of 15? Why would we make a difference? **Dr. Garzon:** It is an optional scope and it is something that we are starting. I want to QI the use of supraglottic airways by EMT's and I want to start with adults and seeing the success we have there. If it proves successful and EMT's have experience doing it, then I am happy to move to the pediatric age group and take it down to 8. My rationale is that this is a new optional score for EMT's in Sacramento County. I want to start with adults first. I am open to moving it to 8 once we know EMT's are experienced with it and using it appropriately and successfully in the adult population. **APPROVED** **Kathy Ivy:** For the supraglottic airway, I am looking at the scope of practice from EMSA and it states it is for adults only for EMT's. **Ketamine for psychiatric and behavioral emergencies:** **Dr. Garzon:** This is not a policy, but a discussion about the use of Ketamine in behavioral emergencies. I know that Dr. Mackey and several others have been in favor of doing this. I am looking at this as, are we solving a problem that we do not have, and what is the experience out there. A review was done of other LEMSA's in California. You can see on the screen what options other counties use for	Dave Magnino/Kristin Bianco to set up meeting with law enforcement regarding PD# 8062

	behavioral emergencies. The most common agent used is Midazolam. The program, 60 Minutes did a segment on the use of Ketamine in EMS that was concerning. We have Midazolam and I am not ready to add Ketamine as an option for behavioral emergencies at this point. **Dave Buettner:** What are the number of behavioral emergency calls SEMSA handles and how many have had Midazolam been used for? **Dr. Garzon:** Dorthy just ran the data from January 2020-December 2020. 7,236 calls for behavioral emergencies have been run this year. There have been 128 uses of Midazolam. **Barbie Law:** What about changing language on restraining prone? **Dr. Garzon:** We are tabling the restraint policy until we talk to Law Enforcement. **Barbie Law:** My point on that is that I think we need to clearly prohibit restraining in that manner. The policy does not clearly state that. It states to 'avoid' it but I think it should not be done at all. **Dr. Garzon:** Noted, and I agree **Kathy Ivy:** I can make the edit. **Dr. Garzon:** We will make that update. Before we move on from behavioral restraint, one of the other topics is to develop a pediatric policy that would include Chemical Restraint. I do concur with this. We are working on it and it is still on the table. **Kristin Bianco:** Through discussion between Kathy and me, we were thinking an age limit of 12 years old. If you medicate below 12, it would require Base Contact. **Dr. Garzon:** In developing this policy we will be looking at what other LEMSA's are using and using that information as a guideline. Once we have a draft we will put it out to the MAC/OAC for everyone to comment. **Dr. Beckerman:** I like what Alameda County has done with Olanzapine for cooperative patients. It is my go-to in the ED and can save having to go IM. This is supported by Dr. Scott Zeller, who is an expert in emergency psychiatry. **Dr. Garzon:** I will take a look at this as well.	
Supplemental New Business: • PD# 2510-Designation Requirements for Ground Based ALS Service Providers • PD# 4400-Paramedic Accreditation to Practice	**PD#-2510** **Kristin Bianco:** We pulled this out of turn because we are adding additional language for ALS providers that want to come to Sacramento County in the future. They will be required to provide Emergency Medical Dispatch (EMD) entity requirements per PD# 2501. The language was not in PD# 2510. **Dr. Garzon:** Someone had asked why we were trying to change this policy. We had a new provider that wanted to provide services to Sacramento County, but had no EM Dispatch process in place. After review of PD# 2510, we realized it was not required in this policy. This policy was edited to address new who may want to apply to be an ALS provider in the county. This is not an issue with any	

	existing Sacramento County provider. All current providers are doing everything they should and everything that is now in this policy. **Barbie Law:** Can language be added to clearly state that this applies to applications beginning on a certain date, and not retroactive? **Dr. Garzon:** You are already doing this. Even if it was applied retroactively, everyone is already complying. I don't know why we have to draw a distinction to these things that you are already doing. **Barbie Law:** Other parts of that policy talk about having ALS agreements in place that are a point of concern right now. I think the Fire service would feel comfortable if it was very clear in this policy that we are not going to turn around and require additional things. I think the entire policy needs to be clear that all of the elements that are added are 'moving forward'. **Kristin Bianco:** Nothing has changed. We added language from PD# 2501 into PD# 2510 to make it easier for ALS providers that are trying to come into Sacramento County to have all of the information in one place. **Dr. Garzon:** Barbie, what is it in this policy that you don't think the fire service is doing? **Barbie Law:** I wouldn't say we are not doing it. As of right now you know there is some concern regarding if we have and ALS agreement or do we not have an ALS agreement or does the fire service have a settlement agreement. What I don't want if for this policy to be used to say that we have to have an ALS agreement. I am out of town and I can't see the screen so I may be thinking about the wrong policy. **Dr. Garzon:** Your point is taken. All current providers are doing what is stated in this policy. This policy does not talk about an ALS agreement, which is a whole different conversation. It is a political and legal conversation and it does not relate to any language in this policy. I do not see a need to call out that this is not retroactive. It only applies to new providers. All of the current providers are complying with everything in here. Your point is taken will be noted in the minutes but I am not going to make the update. **APPROVED** **PD#-4400** **Kristin Bianco:** We cleaned up language to make it more clear that in order to maintain a Sacramento County accreditation, Paramedics must keep their accreditation current, follow all SCEMSA policy, maintain employment as a Paramedic with a Sacramento County ALS provider, and submit for continuous accreditation prior to expiration. It also serves as a reminder that if a Paramedic separates from your agency, it is the agencies responsibility to notify SCEMSA. We clarified the application for continuance of Paramedic accreditation and that late submission may cause a lapse in continuous accreditation subjecting the Paramedic to renewal fees and the inability to work. We have had quite a few Paramedics letting their accreditation lapse, employers not notifying SCEMSA of Paramedics that have separated from their agency. Accela automatically sends out an email, listing the Paramedics and	

	EMT's that currently work for your agency. When your agency receives the list, it is your responsibility to go through it and let us know who has separated from your agency and to make sure all of your current employees are listed. **Dr. Garzon:** Any additional comments or thoughts about this policy? **APPROVED**	
Scheduled Program Documents for Review: • PD# 2521-Ambulance Patient Offload Time (APOT) • PD# 2523-Administration of Naloxone • PD# 4160-EMR Initial Certification • PD# 4200-Mobile Intensive Care Nurse (MICN) Certification • PD# 4201-Mobile Intensive Care Nurse (MICN)-Recertification • PD# 4503-Public Safety EMT AED Service Provider Approval • PD# 4504-AED Medical Control • PD# 8060- Stroke • PD# 8061-Decreased Sensorium • PD# 8810-Transcutaneous Cardiac Pacing • PD# 8829-Noninvasive Ventilatory (NIV)	**PD# 2521-Ambulance Patient Offload Time (APOT)** **Dr. Garzon:** in the APOT 3, we added accumulative time in hours spent on the wall. We are looking at the cost to the EMS system in man-hours. We did not receive any public comments on this policy. Also changed was after 60 minutes of wall time instead of 30 minutes, the EMS duty officer should be notified. **APPROVED** **PD# 2523-Administration of Naloxone** **Dr. Garzon:** Added is for law enforcement, within 48 hours after administration it needs to be reported to SCEMSA. There were some comments made on the public comment form and those suggestions were adopted. **APPROVED** **PD# 4160-EMR Initial Certification** **Dr. Garzon:** On this policy we changed the training and eligibility requirements. The course completion record has to be within the last 24 months instead of 12 months. **APPROVED** **PD# 4200-Mobile Intensive Care Nurse (MICN) Certification** **Dr. Garzon:** Kathy Ivy received a comment this morning that there is no language regarding the 'term of forgiveness' if someone falsifies documents. Following with the state and the term we have for Paramedics is one year before they can re-apply. We will add to the policy and then bring it back in March. **BRING BACK IN MARCH 2021** **PD# 4201-Mobile Intensive Care Nurse (MICN) Recertification** **Dr. Garzon:** Language clean up only. I think if we put in the 'term of forgiveness' regarding falsification into PD# 4200, we should add it to this one. **BRING BACK IN MARCH 2021** **PD# 4503-Public Safety EMT AED Service Provider Approval** **Dr. Garzon:** Definitions were cleaned up. **APPROVED** **PD# 4504-AED Medical Control** **Dr. Garzon:** Clean up of language. **APPROVED** **PD# 8060-Stroke** **Dr. Garzon:** There is a comment regarding new onset of ALOC and GCS <14, do we want the Paramedics to call a stroke alert with an indeterminate stroke scale? I don't think the policy could be more clear, a stroke alert is called when the stroke scale is other than "0" not for when it is indeterminate, not when you have a patient that is generally confused. A stroke alert should only be	

• PD# 8831-Intranasal Medication Administration • PD# 9019-Brief Resolved Unexplained Event (BRUE) • PD# 9020-Pediatric Nausea and or Vomiting	called when the stroke scale is again, other than "0." I think it is a training point more than a policy issue. **APPROVED** **PD# 8061-Decreased Sensorium** **Dr. Garzon:** I want to take this back for some editing so there is initially an approach to all decreased sensorium and not specifically call out treating hypoglycemia, treating seizure or treating suspected opiate base on presentation. Supplemental oxygen when needed, adjunctive airways, or IV's etc. should be common to all decreased sensorium. So we will take this back for some editing and bring it back in March. **BRING BACK IN MARCH 2021** **PD# 8810-Transcutaneous Cardiac Pacing** **Dr. Garzon:** Grammatical edits, otherwise no changes to this policy. **APPROVED** **PD# 8829-Noninvasive Ventilatory (NIV)** **Dr. Garzon:** Grammatical edits, otherwise no changes to this policy. **APPROVED** **PD# 8831-Intranasal Medication Administration** **Dr. Garzon:** Grammatical edits, otherwise no changes to this policy. **APPROVED** **PD# 9019-Brief Resolved Unexplained Event (BRUE)** **Dr. Garzon:** We did have one comment from Dr. Walsh, that one potential addition would be 94% or the child's baseline oxygen if the child has a history of cyanotic heart disease. I think that would add more confusion. We will not be adopting that comment. **APPROVED** **PD# 9020-Pediatric Nausea and or Vomiting** **Dr. Garzon:** Grammatical edits. A cross reference of PD 9013-Pediatric Shock. Add fluid bolus x 1 of normal saline. **BRING BACK IN MARCH 2021**	
Roundtable:	**Ben Merin:** I wanted to give an update regarding COVID vaccinations. First Responders are in the 1B tier. The county has not received its allocation yet. Hospitals have received their pre-designated allocations. We are having a call this afternoon with Public Health and Dr. Mackey will be on that call to start rolling it out for the EMS providers. The tentative plan is that you will not need to sign up for the reporting program. Public Health is going to work with each agency. There will be an email address on the counties COVID page. They are asking that you email that email address with your agency contact information, number of field employees – not office staff or dispatchers, just strictly EMT's and Paramedics that work in the field, how many are in your organization and then they will coordinate directly with you to come out with a Public Health Nurse and oversee the vaccination process. You will be able by optional scope to administer the vaccinations to your employees, even if you are a Paramedic; they still have to have the Public Health Nurse oversee the program. If you have any questions, you can contact Public Health directly.	

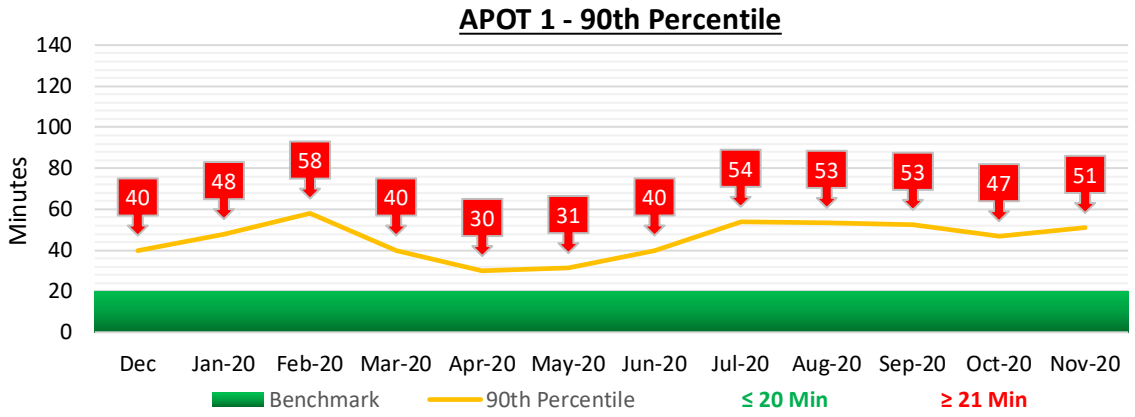
	Dr. Garzon: By the policy that we sent out for the optional scope, Paramedics giving vaccinations you will have to have a program in place and in advance of doing that, SCEMSA has to have the documentation that is required. Please get that in if your medics are going to be participating in the vaccination program. California is expecting two million doses. One million doses are slotted for this week. The Pfizer, we are getting three hundred twenty-seven doses this week. We will be getting Seven hundred-seventy three doses from Moderna. Moderna is coming in beginning next Monday. Both of them are 94%-95% effective. The state of California has somewhere between 2.4 and 2.5 million health care people that are in the health care work force. **Dorthy Rodriguez:** This is the ePCR's for last quarter. These are the reported ePCR's for each provider and the ePCR's that SCEMSA actually received. When you look at the percentage, those are the percentages of what is missing. We are missing quite a bit of ePCR's and this is just for one quarter. We really need to get better at checking the export report for each provider, to make sure that anything that fails makes it across. If it fails on your end, I cannot see it. There is no way for me to know, other than to do this audit at the end of each quarter. Next month, I will be sending all of you a request for totals to see how we are doing. **Dr. Garzon:** This is obviously very important. We have to work with Dorthy to get these issues resolved. We now have Brandon who is from Pulsara to do a quick presentation. The one way that I see this working is to start small and then increase. Perhaps work with one the ALS providers and two or three of the most common hospitals as a way to begin adoption if they are interested. That would also give us local information on its use. We can take this conversation on to future meetings and I look forward to continued dialogue about potential use. Thank you everyone for participating.	
Adjournment:	Adjournment: 12:00 PM	

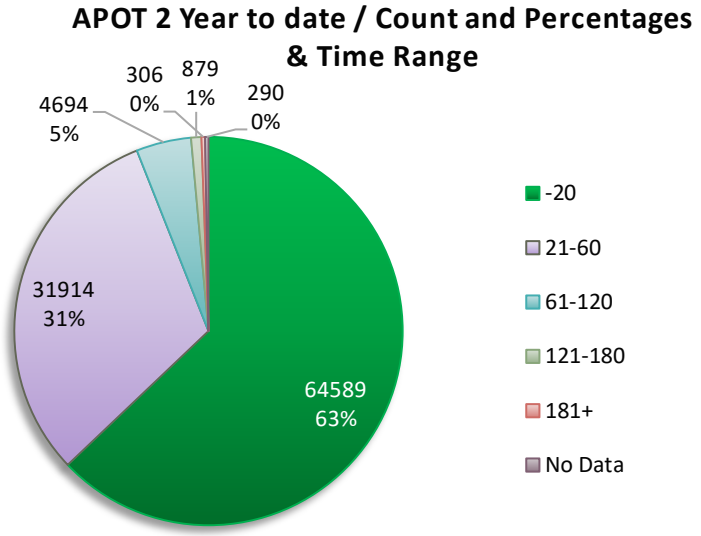
Next MAC/OAC Meeting: March 11, 2021

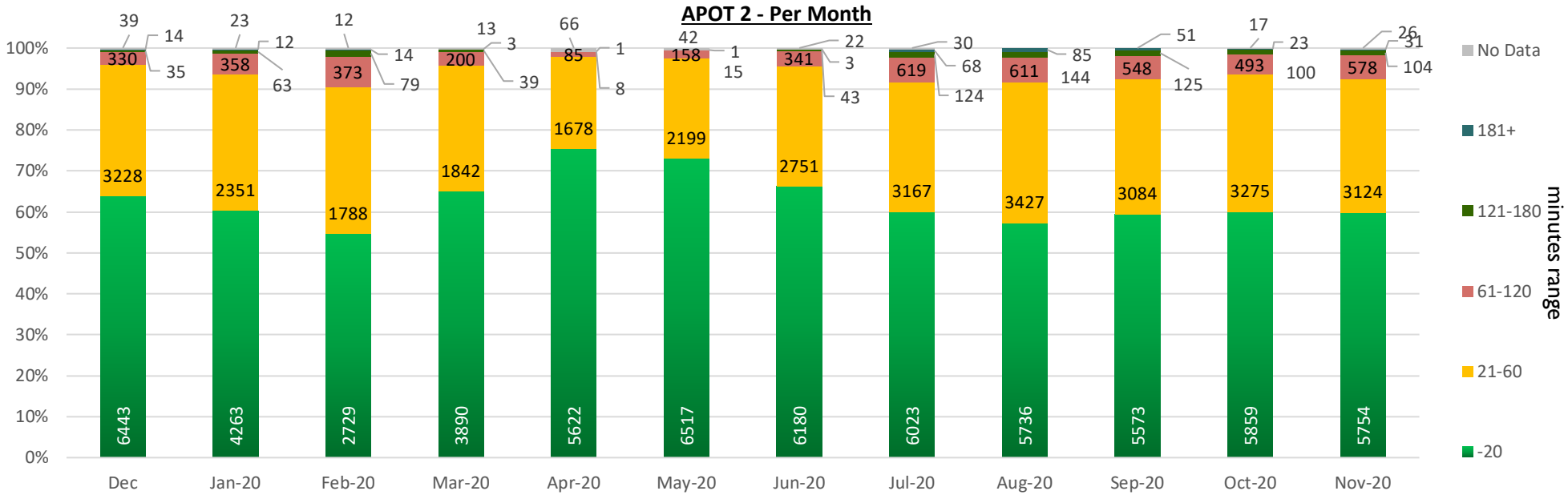
SYSTEM APOT 1 & 2 / 2019 -2020 / ROLLING 12 MONTHS

APOT-1 represents the time (in minutes) under which 90% of patients have their care transferred from EMS to hospital staff. APOT-2 is the percentage of patients whose care is transferred from EMS to hospital staff by designated time frames (see graph key for time frames).

Jan 2020 – Nov 2020 cumulative APOT 90%: **46** / Average: **23**





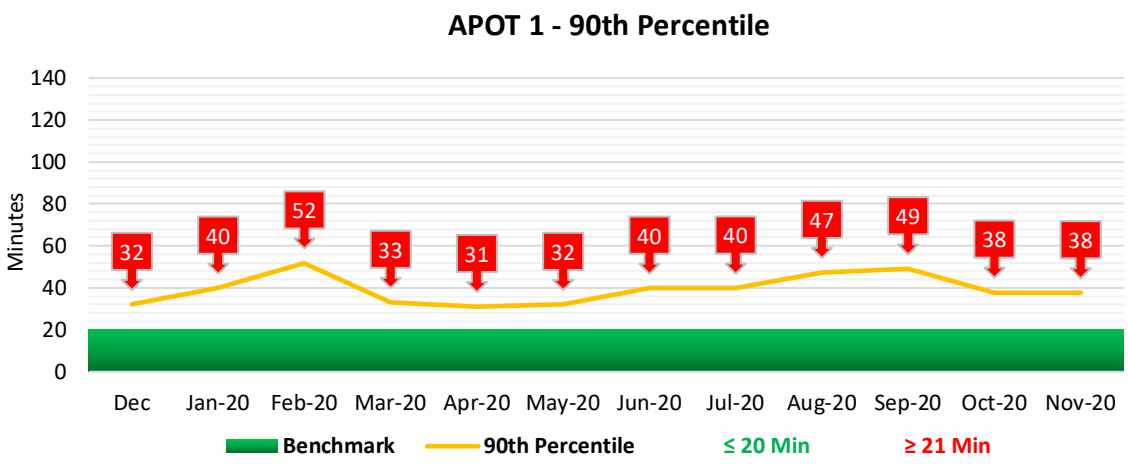


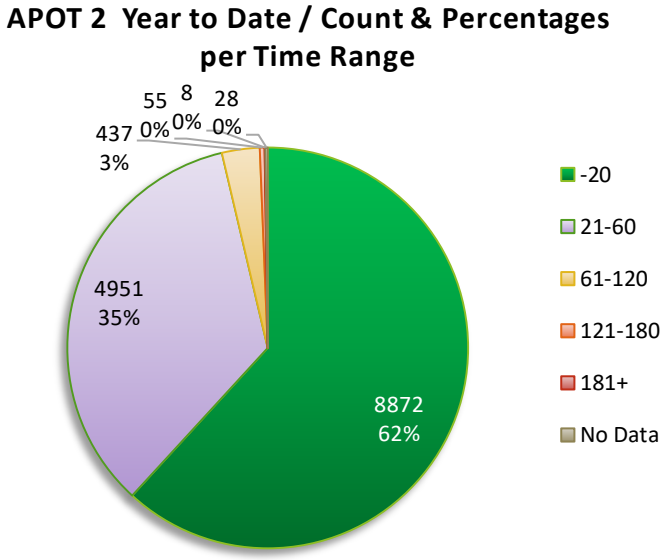
Completed by: Sacramento County Emergency Medical Services Agency (SCEMSA) Updated: 12.1.2020

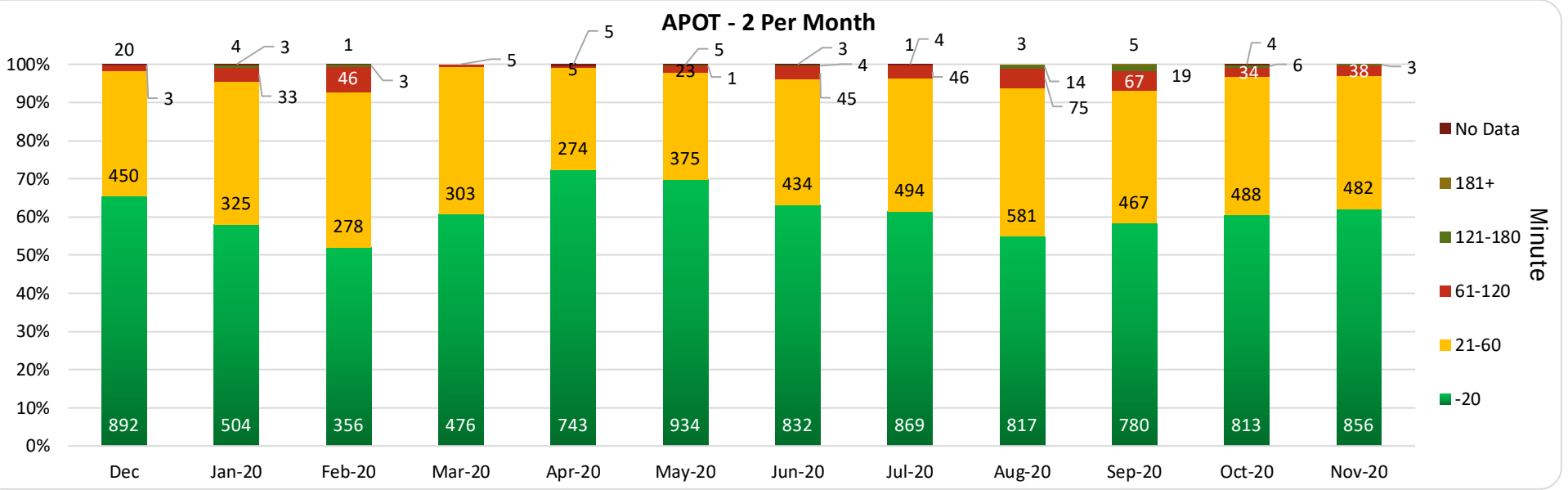
KAISER NORTH APOT 1 & 2 / 2019-2020 / ROLLING 12 MONTHS

APOT-1 represents the time (in minutes) under which 90% of patients have their care transferred from EMS to hospital staff. APOT-2 is the percentage of patients whose care is transferred from EMS to hospital staff by designated time frames (see graph key for time frames).

Jan 2020 – Nov 2020 cumulative APOT 90%: **40** / Average: **22**





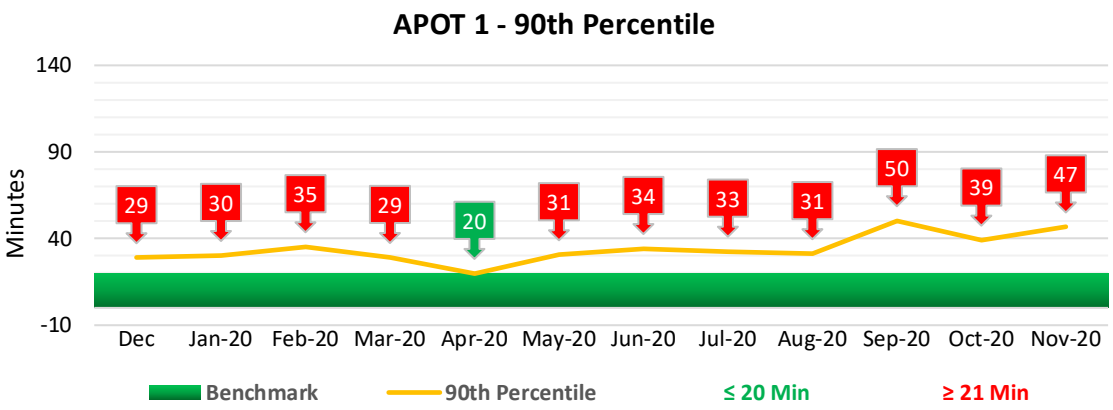


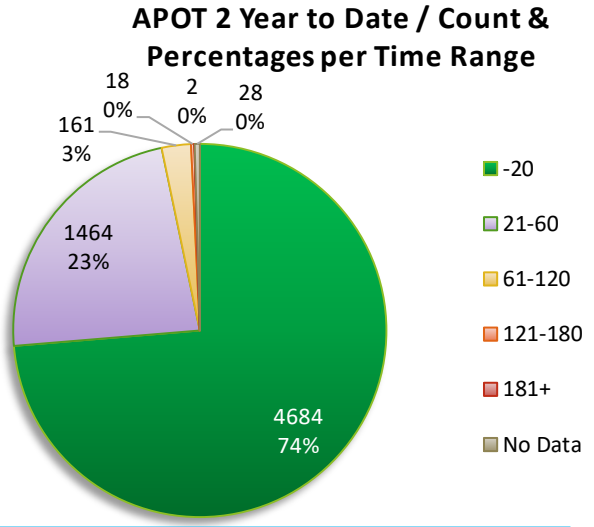
Completed by: Sacramento County Emergency Medical Services Agency (SCEMSA) Updated: 12.1.2020

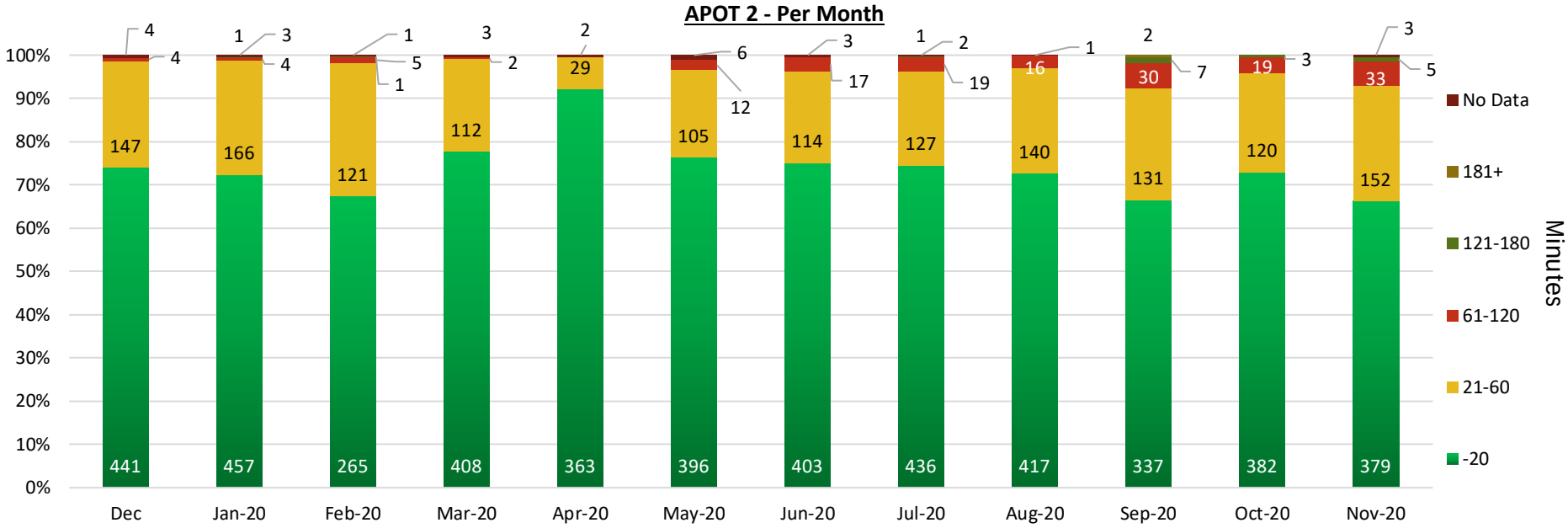
KAISER ROSEVILLE APOT 1 & 2 / 2019 -2020 / ROLLING 12 MONTHS

APOT-1 represents the time (in minutes) under which 90% of patients have their care transferred from EMS to hospital staff. APOT-2 is the percentage of patients whose care is transferred from EMS to hospital staff by designated time frames (see graph key for time frames).

Jan 2020 – Nov 2020 cumulative APOT 90%: **34** / Average: **19**





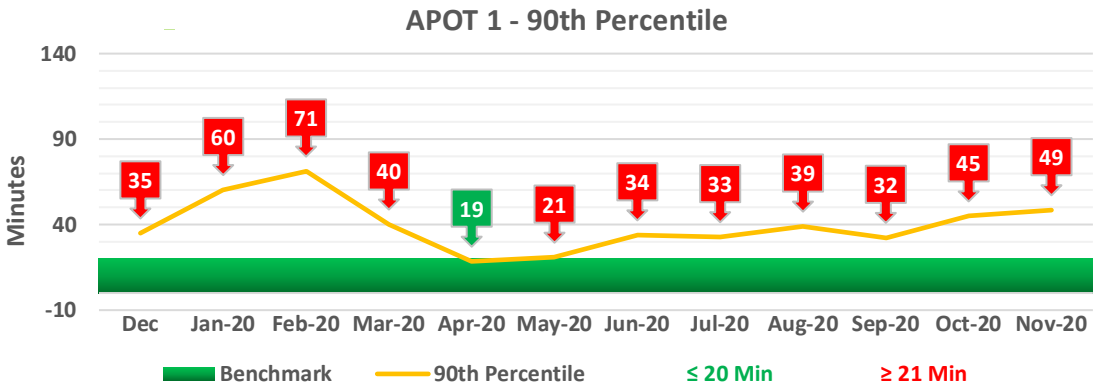


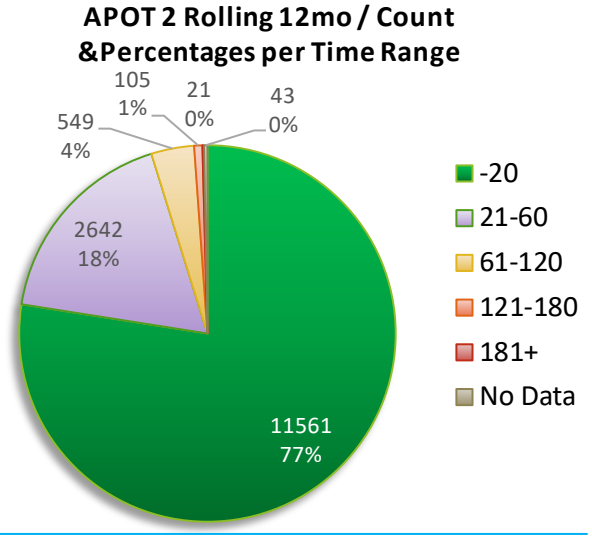
Completed by: Sacramento County Emergency Medical Services Agency (SCEMSA) Updated: 12.2.2020

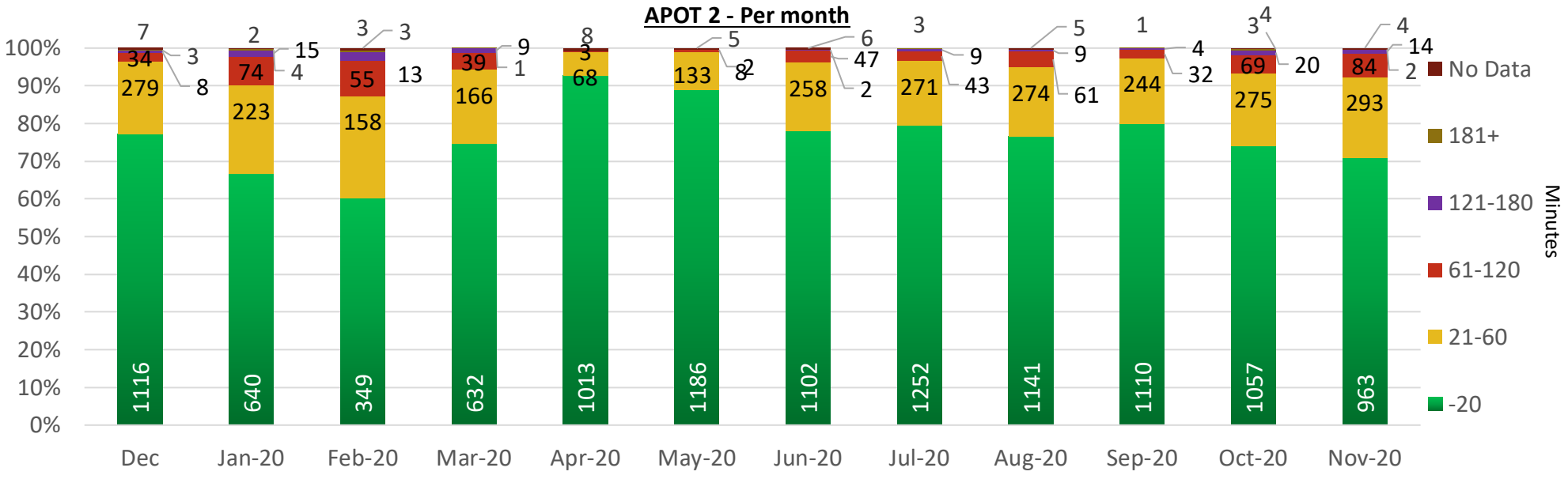
KAISER SOUTH APOT 1 & 2 / 2019-2020 / ROLLING 12 MONTHS

APOT-1 represents the time (in minutes) under which 90% of patients have their care transferred from EMS to hospital staff. APOT-2 is the percentage of patients whose care is transferred from EMS to hospital staff by designated time frames (see graph key for time frames).

Jan 2020 - Nov 2020 cumulative APOT 90%: **38** / Average: **19**





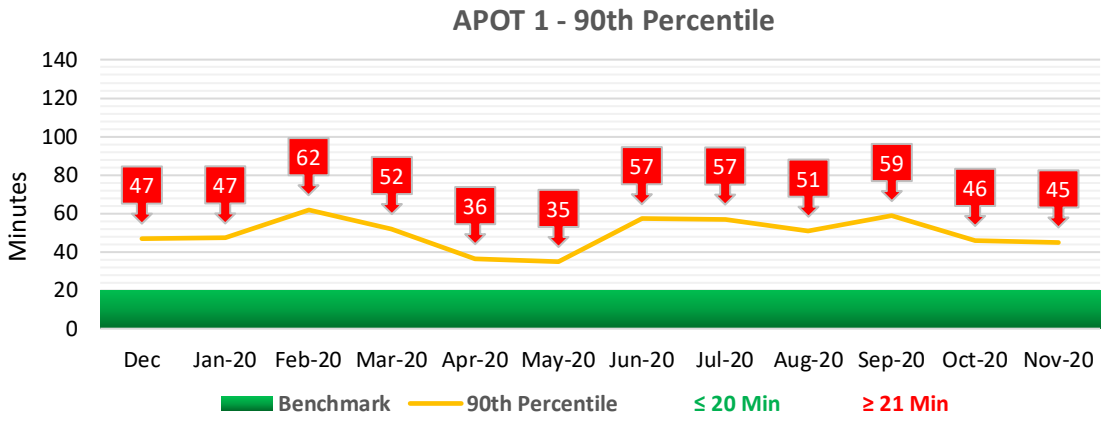


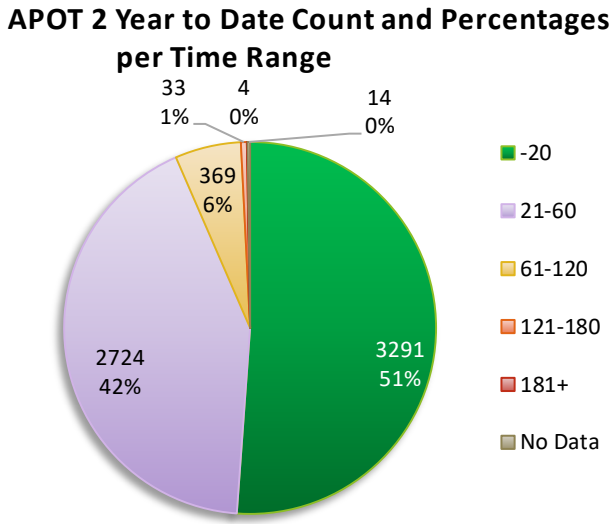
Completed by: Sacramento County Emergency Medical Services Agency (SCEMSA) Updated: 12.1.2020

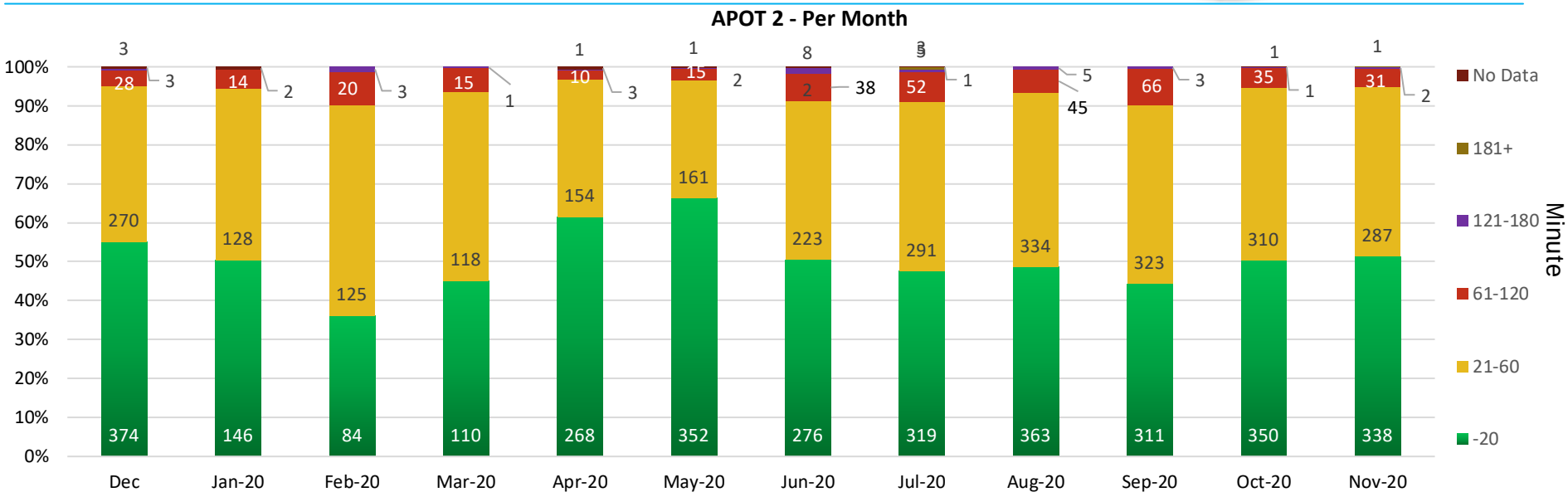
MERCY GENERAL APOT 1 & 2 / 2019 -2020 / ROLLING 12 MONTHS

APOT-1 represents the time (in minutes) under which 90% of patients have their care transferred from EMS to hospital staff. APOT-2 is the percentage of patients whose care is transferred from EMS to hospital staff by designated time frames (see graph key for time frames).

Jan 2020 – Nov 2020 cumulative APOT 90%: **50** / Average: **26**





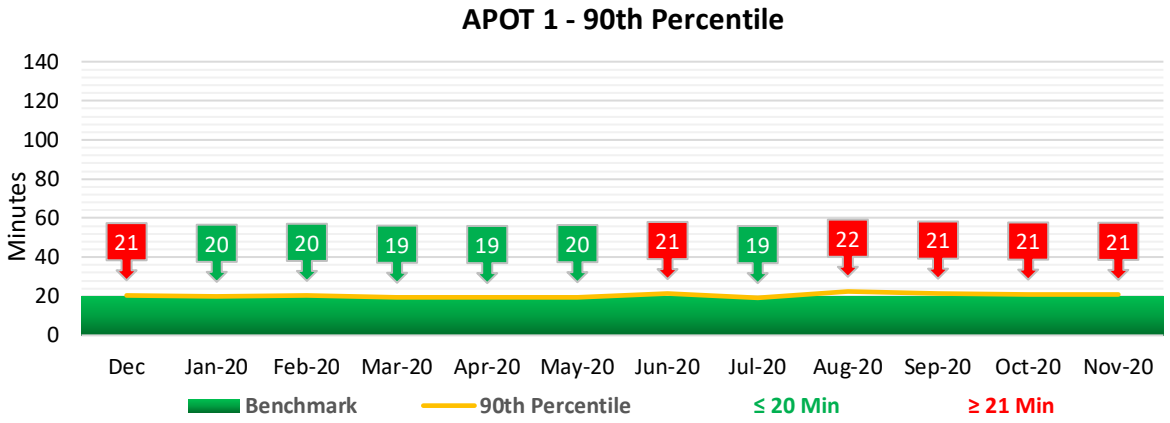


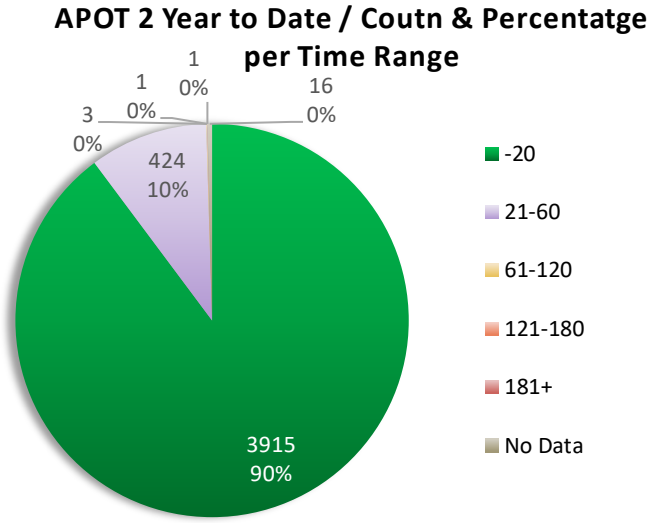
Completed by: Sacramento County Emergency Medical Services Agency (SCEMSA) Updated: 12.2.2020

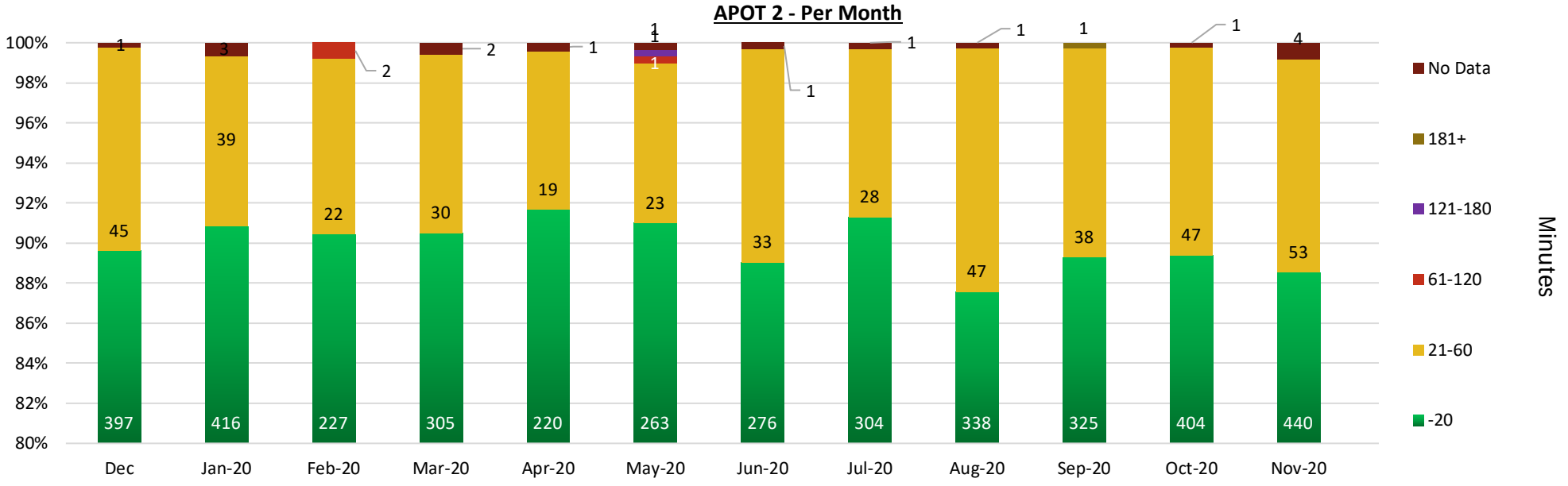
MERCY OF FOLSOM APOT 1 & 2 / 2019 -2020 / ROLLING 12 MONTHS

APOT-1 represents the time (in minutes) under which 90% of patients have their care transferred from EMS to hospital staff. APOT-2 is the percentage of patients whose care is transferred from EMS to hospital staff by designated time frames (see graph key for time frames).

Jan 20 – Nov 20 cumulative APOT 90%: **20** / Average: **11**







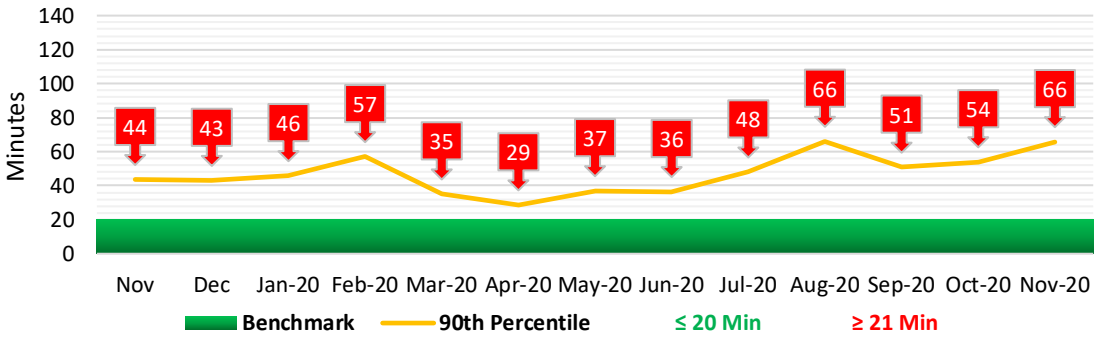
Completed by: Sacramento County Emergency Medical Services Agency (SCEMSA) Updated: 12.2.2020

MERCY SAN JUAN APOT 1 & 2 / 2019 -2020 / ROLLING 12 MONTHS

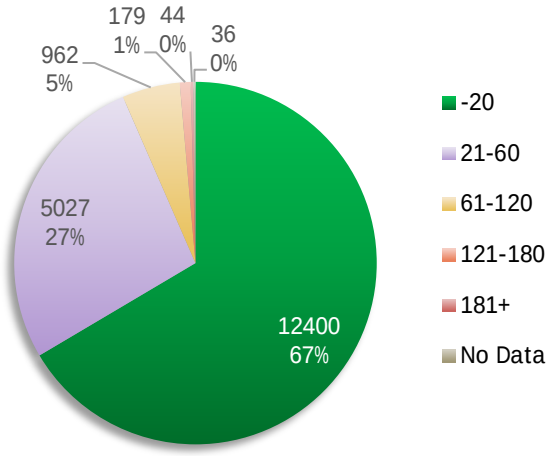
APOT-1 represents the time (in minutes) under which 90% of patients have their care transferred from EMS to hospital staff. APOT-2 is the percentage of patients whose care is transferred from EMS to hospital staff by designated time frames (see graph key for time frames).

Jan 2020 - Nov 2020 cumulative APOT 90%: **47** / Average: **23**

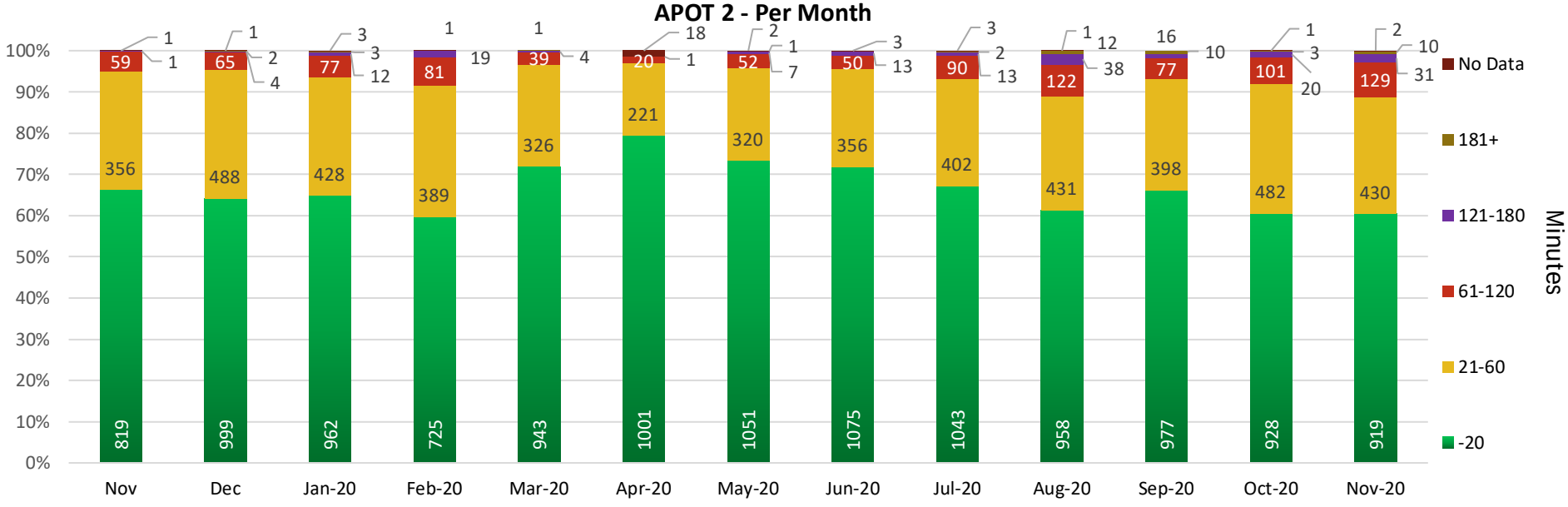
APOT 1 - 90th Percentile



APOT 2 Year to Date / Count & Percentage per Time Range



APOT 2 - Per Month

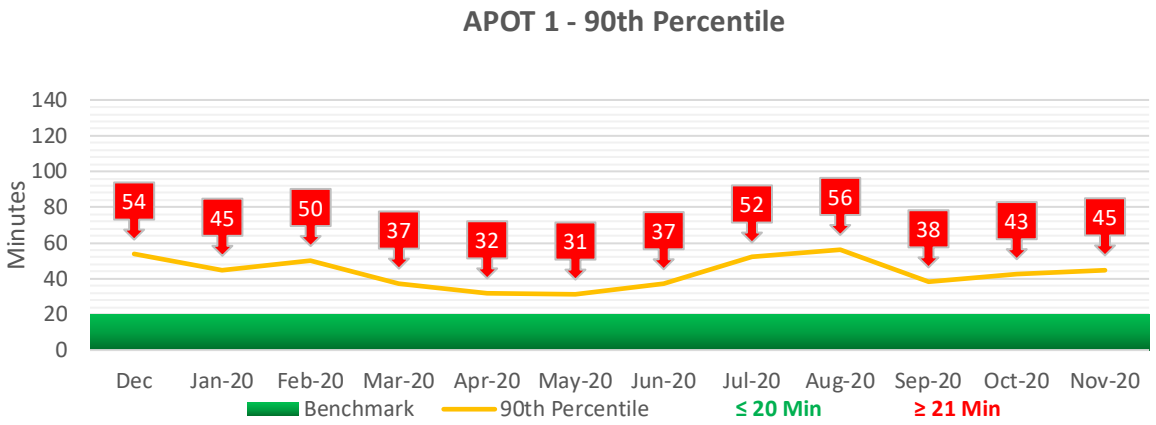


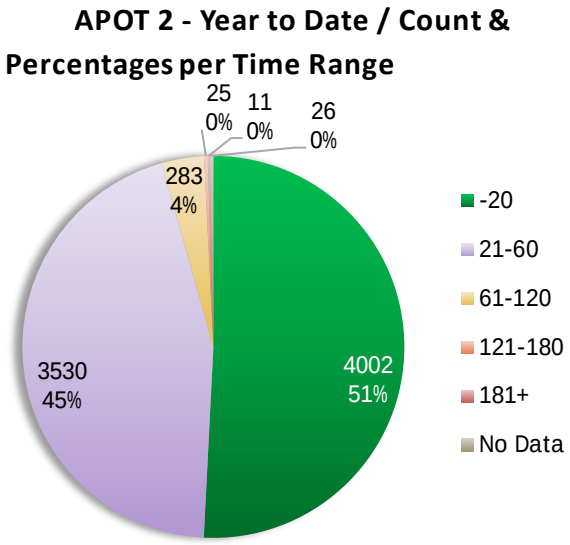
Completed by: Sacramento County Emergency Medical Services Agency (SCEMSA) Updated: 12.2.2020

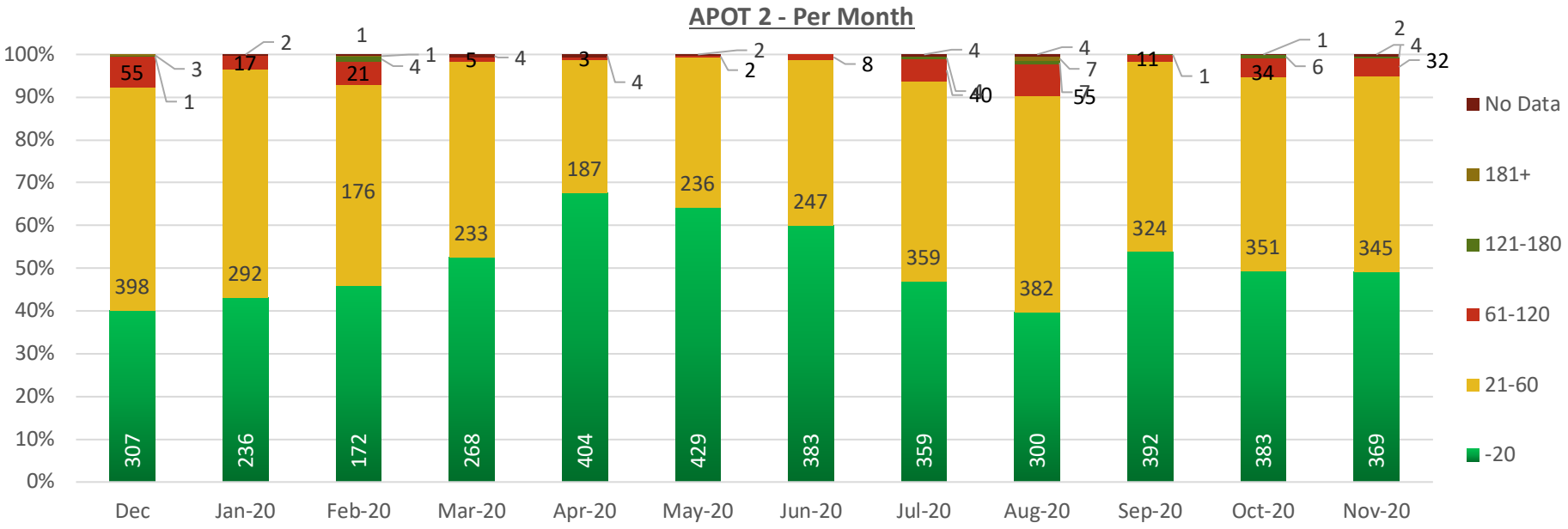
METHODIST APOT 1 & 2 / 2019 - 2020 / ROLLING 12 MONTHS

APOT-1 represents the time (in minutes) under which 90% of patients have their care transferred from EMS to hospital staff. APOT-2 is the percentage of patients whose care is transferred from EMS to hospital staff by designated time frames (see graph key for time frames).

Jan 2020 – Nov 2020 cumulative APOT 90%: **42** / Average: **24**





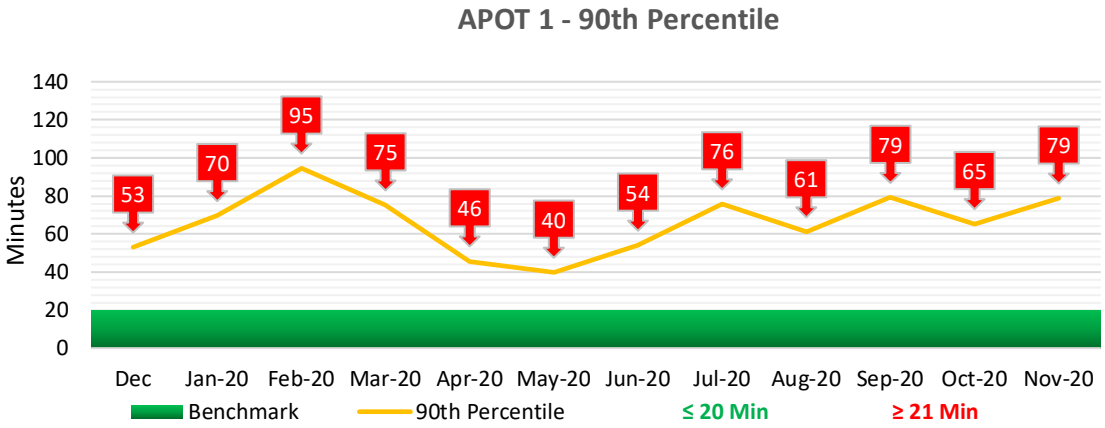


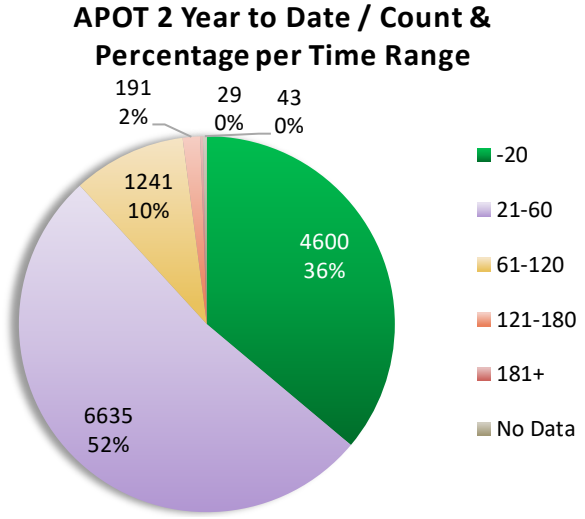
Completed by: Sacramento County Emergency Medical Services Agency (SCEMSA) Updated: 12.2.2020

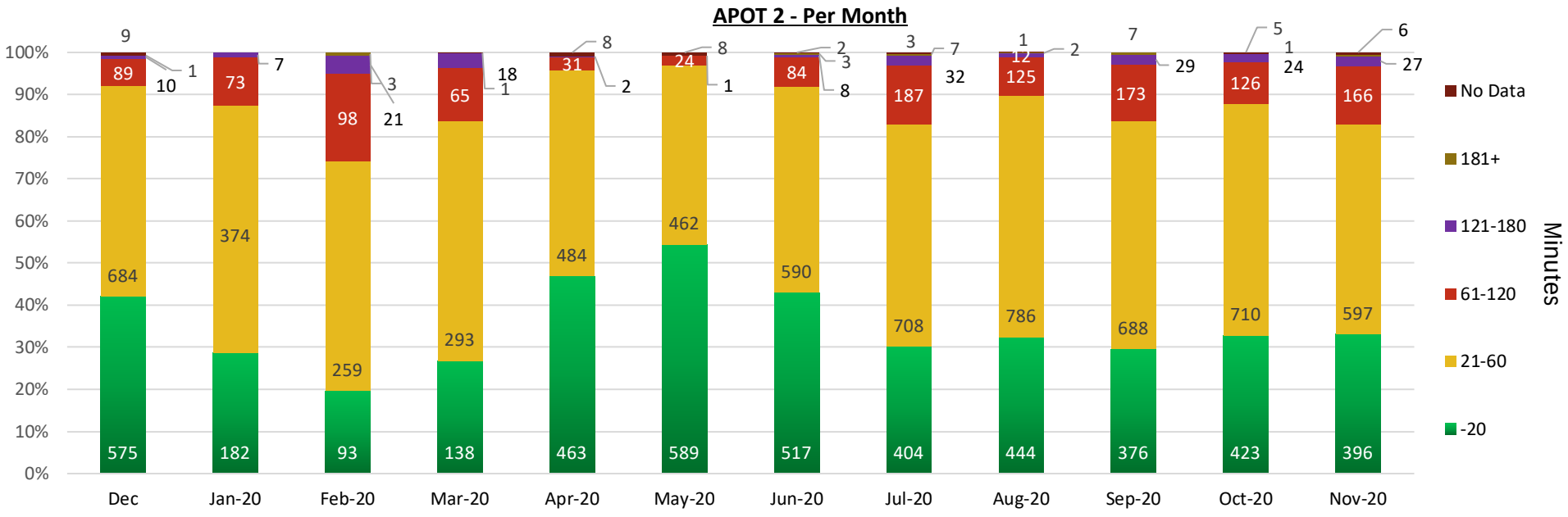
SUTTER GENERAL APOT 1 & 2 / 2019 -2020 / ROLLING 12 MONTHS

APOT-1 represents the time (in minutes) under which 90% of patients have their care transferred from EMS to hospital staff. APOT-2 is the percentage of patients whose care is transferred from EMS to hospital staff by designated time frames (see graph key for time frames).

Jan 2020 – Nov 2020 cumulative APOT 90%: **66** / Average: **34**





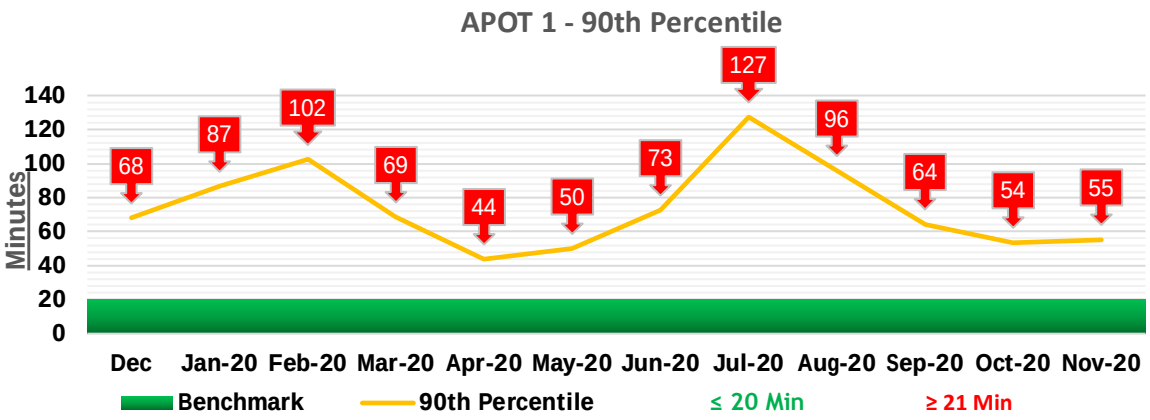


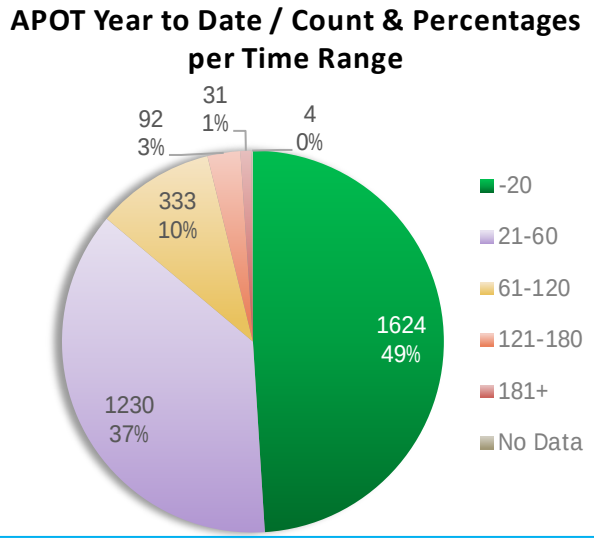
Completed by: Sacramento County Emergency Medical Services Agency (SCEMSA) Updated: 12.2.2020

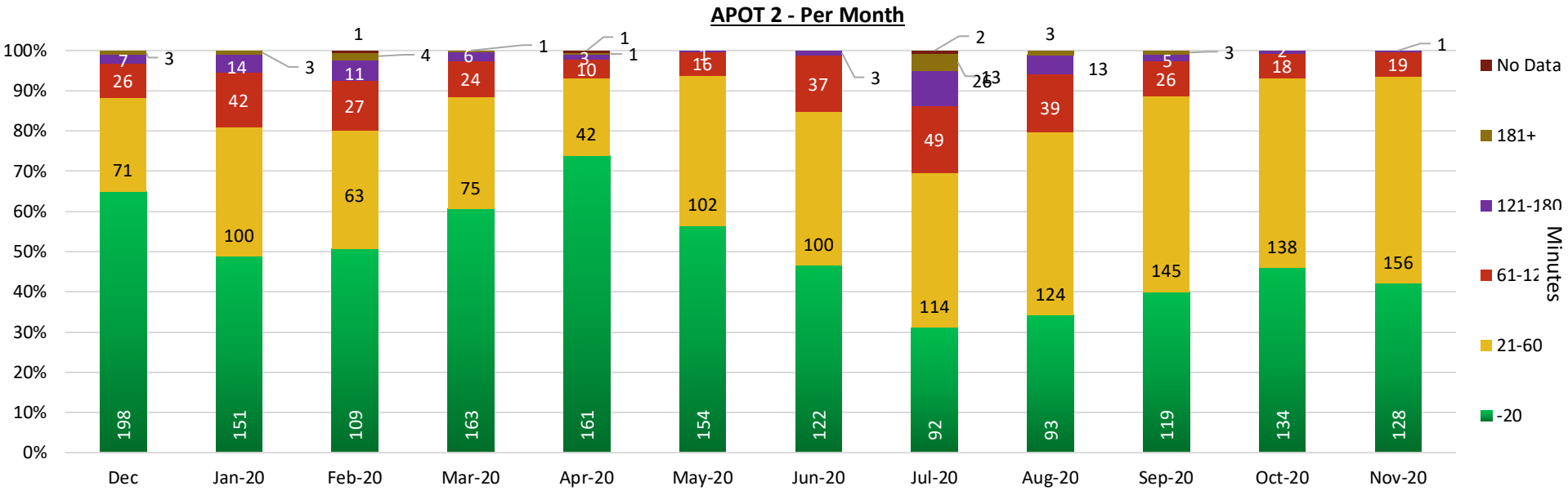
SUTTER ROSEVILLE APOT 1 & 2 / 2019 - 2020 / ROLLING 12 MONTHS

APOT-1 represents the time (in minutes) under which 90% of patients have their care transferred from EMS to hospital staff. APOT-2 is the percentage of patients whose care is transferred from EMS to hospital staff by designated time frames (see graph key for time frames).

Jan 20 - Nov 20 cumulative APOT 90%: **74** / Average: **33**





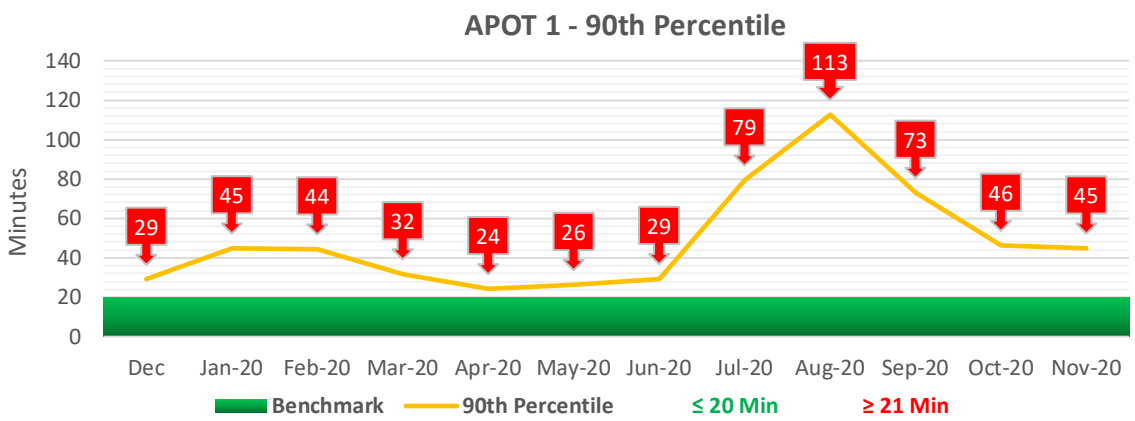


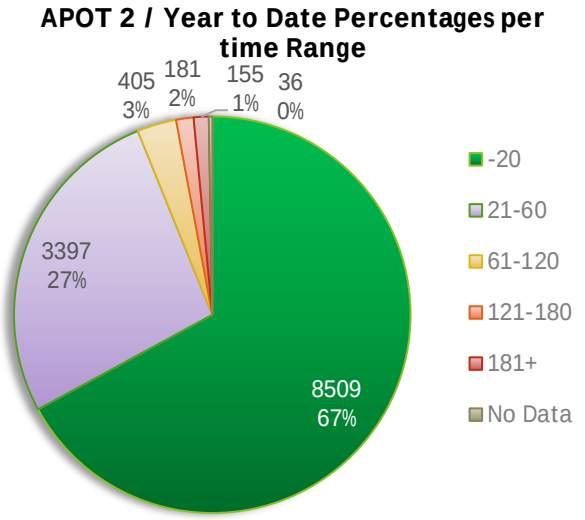
Completed by: Sacramento County Emergency Medical Services Agency (SCEMSA) Updated: 12.2.2020

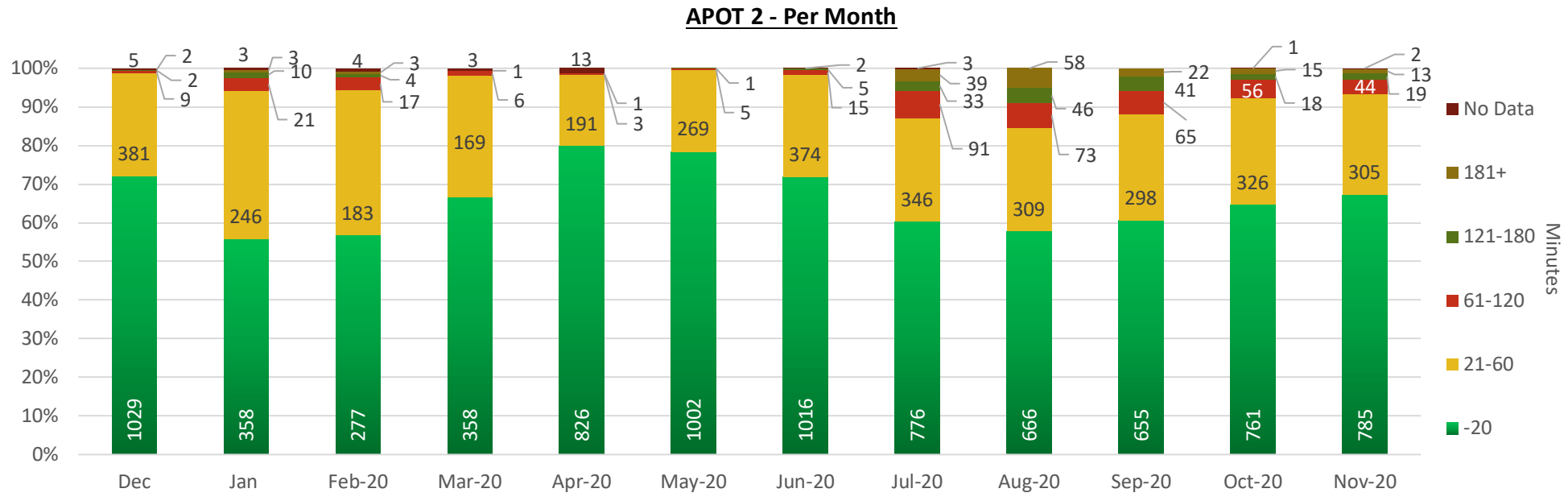
UC DAVIS APOT 1 & 2 / 2019 - 2020 / ROLLING 12 MONTHS

APOT-1 represents the time (in minutes) under which 90% of patients have their care transferred from EMS to hospital staff. APOT-2 is the percentage of patients whose care is transferred from EMS to hospital staff by designated time frames (see graph key for time frames).

Jan 2020 – Nov 2020 cumulative APOT 90%: **42** / Average: **25**





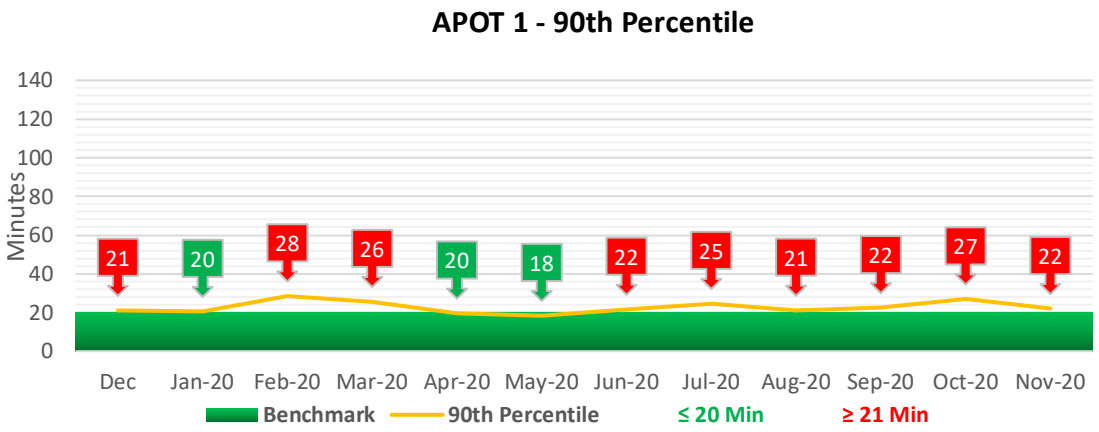


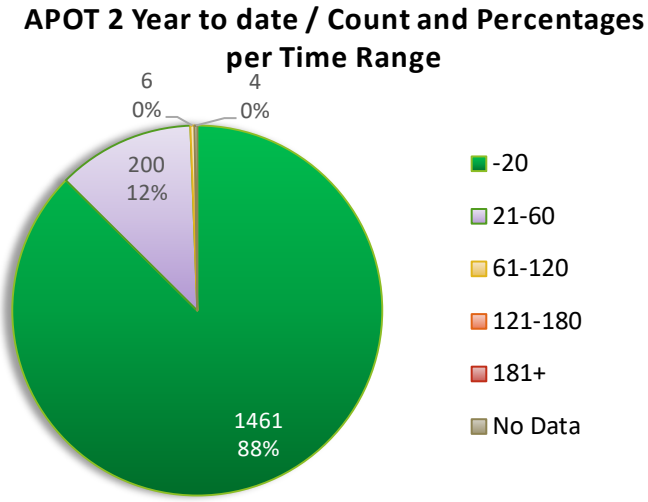
Completed by: Sacramento County Emergency Medical Services Agency (SCEMSA) Updated: 12.02.2020

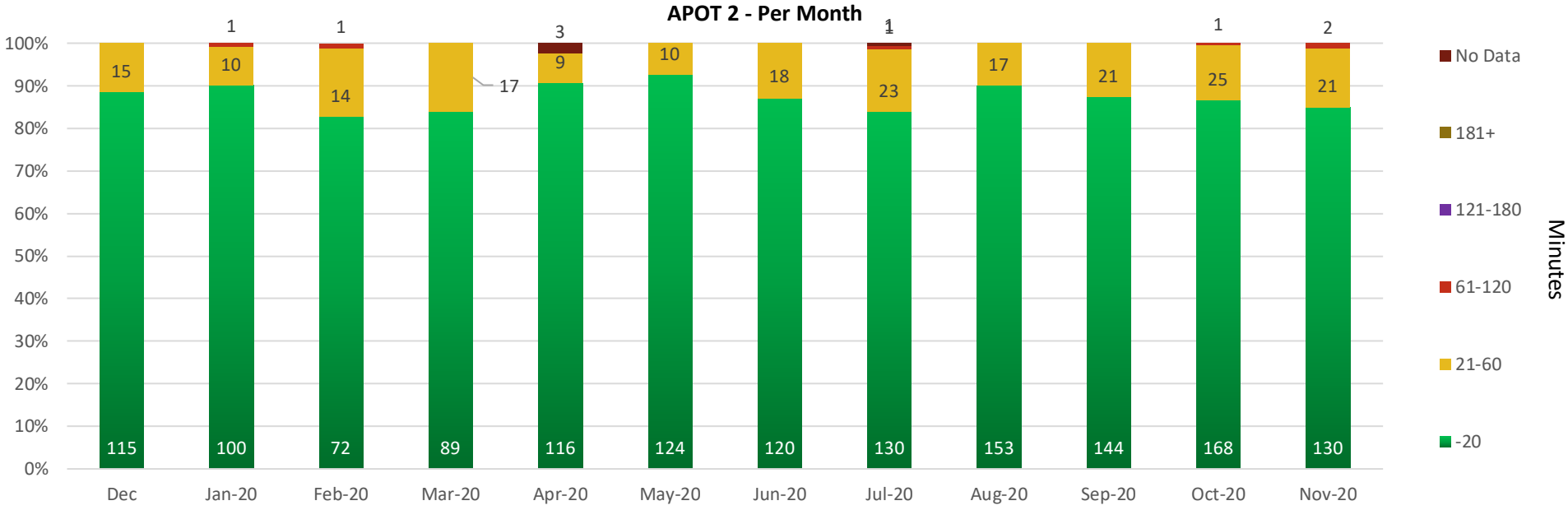
VA APOT 1 & 2 / 2019 - 2020 / ROLLING 12 MONTHS

APOT-1 represents the time (in minutes) under which 90% of patients have their care transferred from EMS to hospital staff. APOT-2 is the percentage of patients whose care is transferred from EMS to hospital staff by designated time frames (see graph key for time frames).

Jan 2020 – Nov 2020 cumulative APOT 90%: **22** / Average: **12**



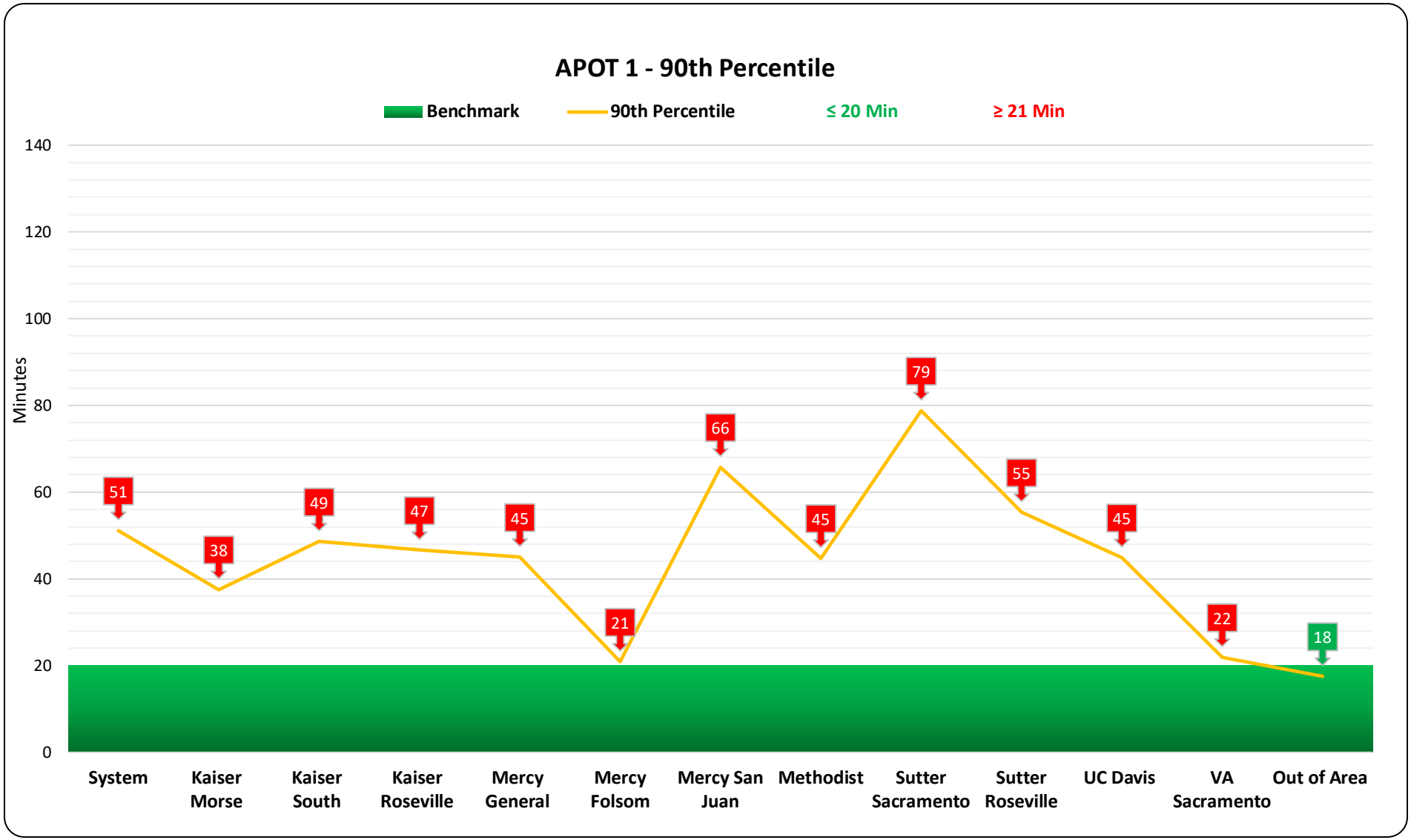




Completed by: Sacramento County Emergency Medical Services Agency (SCEMSA) Updated: 12.2.2020

90TH PERCENTILE PER HOSPITAL / OCTOBER - 2020

APOT-1 represents the time (in minutes) under which 90% of patients have their care transferred from EMS to hospital staff. The graph below illustrates the APOT time per hospital for the month of November - 2020.



Completed by: Sacramento County Emergency Medical Services Agency (SCEMSA) Updated: 12.2.2020

TRA-02-Adjusted trauma patients transport to a trauma center	**Num**		7	37	136
	Den		16	39	158
	Percent	N/A	43.75%	94.87%	86.08%
ACS-01 Aspirin administration for chest pain/discomfort	**Num**		49	287	278
	Den		67	376	355
	Percent	N/A	73.13%	76.33%	78.31%
ACS-04- Adjusted Advance hospital notification for STEMI	**Num**		2	24	48
	Den		3	35	58
	Percent	N/A	66.67%	68.57%	82.76%
HYP-01 Treatment administered for hyperglycemia	**Num**	1	9	52	65
	Den	2	13	75	75
	Percent	50.00%	69.23%	69.33%	86.67%
STR-01 Prehospital screening for suspected stroke patients	**Num**	0	7	184	155
	Den	1	19	214	199
	Percent	0.00%	36.84%	85.98%	77.89%
STR-02-Adljusted Prehospital screening for suspected stroke patients	**Num**	0	17	202	194
	Den	1	19	214	199
	Percent	0.00%	89.47%	94.39%	97.49%
STR-04 Prehospital screening for suspected stroke patients	**Num**		3	114	51
	Den		4	114	65
	Percent	N/A	75.00%	100.00%	78.46%
PED-03 Respiratory assessment for pediatric patients	**Num**		11		19
	Den		12	3	21
	Percent	N/A	91.67%	0.00%	90.48%

344	1	62				144
449	1	81				548
76.61%	100.00%	76.54%	N/A	N/A	N/A	26.28%

388	1	144			4	1444
526	2	212			13	1995
73.76%	50.00%	67.92%	N/A	N/A	30.77%	72.38%

27		22				247
33		26				311
81.82%	N/A	84.62%	N/A	N/A	N/A	79.42%

175		60			0	406
249		73			1	795
70.28%	N/A	82.19%	N/A	N/A	0.00%	51.07%

321	1	109	0	1	0	754
359	2	142	1	1	11	826
89.42%	50.00%	76.76%	0.00%	100.00%	0.00%	91.28%

348	0	133	0	0	7	754
359	2	142	1	1	11	826
96.94%	0.00%	93.66%	0.00%	0.00%	63.64%	91.28%

227		71				172
246		92		1		192
92.28%	N/A	77.17%	N/A	0.00%	N/A	89.58%

88	2	5				108
91	2	5			1	113
96.70%	100.00%	100.00%	N/A	N/A	0.00%	95.58%

		SCEMSA
1356	0	**2087**
1616	24	**2932**
83.91%	0.00%	71.18%
2394	9	**4998**
2840	16	**6402**
84.30%	56.25%	78.07%
228		**598**
242	2	**710**
94.21%	0.00%	84.23%
805	2	**1575**
925	6	**2214**
87.03%	33.33%	71.14%
1214	10	**2756**
1255	12	**3042**
96.73%	83.33%	90.60%
1194	11	**2860**
1255	12	**3042**
95.14%	91.67%	94.02%
892		**1530**
986	8	**1708**
90.47%	0.00%	89.58%
171	2	**406**
187	2	**437**
91.44%	100.00%	92.91%

ADJUSTMENTS

- **TRA-02:** Has beed adjusted to count trauma patients transported to Trauma Hospitals by looking at Hospital name (eDisposition.01+02) isntead of looking at hospital capability(eDisposition.23)

- **ACS-04:** Has been adjusted to count STEMI patients transported to a PCI Center by looking at Hospital Name (eDisposition.01+02) isntead of looking at hospital capability (eDisposition.23)

- **STR-02:** Looked at documentation of Glucose under Procedures(eProcedures.03) and vitals (eVitals.18) instead of only looking at vitals (eVitals.18)

TRA-02 trauma patients transport to a	**Num**	0	34	0	36	0
	Den	81	39	158	449	1
	Percent	**0.00%**	**87.18%**	**0.00%**	**8.02%**	**0.00%**
ACS-01 Aspirin administration	**Num**	144	287	278	388	1
	Den	212	376	355	526	2
	Percent	**67.92%**	**76.33%**	**78.31%**	**73.76%**	**50.00%**
ACS-04 Advance hospital	**Num**	0	13	0	6	
	Den	26	35	58	33	
	Percent	**0.00%**	**37.14%**	**0.00%**	**18.18%**	**N/A**
HYP-01 Treatment administered for	**Num**	60	52	65	175	
	Den	73	75	75	249	
	Percent	**82.19%**	**69.33%**	**86.67%**	**70.28%**	**N/A**
STR-01 Prehospital screening for	**Num**	109	184	155	321	1
	Den	142	214	199	359	2
	Percent	**76.76%**	**85.98%**	**77.89%**	**89.42%**	**50.00%**
STR-02 Prehospital screening for	**Num**	45	106	0	8	0
	Den	142	214	199	359	2
	Percent	**31.69%**	**49.53%**	**0.00%**	**2.23%**	**0.00%**
STR-04 Prehospital screening for	**Num**	71	114	51	227	
	Den	92	114	65	246	
	Percent	**77.17%**	**100.00%**	**78.46%**	**92.28%**	**N/A**
PED-03 Respiratory assessment for	**Num**	5	0	19	88	2
	Den	5	3	21	91	2
	Percent	**100.00%**	**0.00%**	**90.48%**	**96.70%**	**100.00%**

0	6	0			319	0
0	16	0			548	1616
N/A	**37.50%**	**N/A**	**N/A**	**N/A**	**58.21%**	**0.00%**

	49			4	1444	2394
	67			13	1995	2840
N/A	**73.13%**	**N/A**	**N/A**	**30.77%**	**72.38%**	**84.30%**

	2				241	0
	3				311	242
N/A	**66.67%**	**N/A**	**N/A**	**N/A**	**77.49%**	**0.00%**

1	9			0	406	805
2	13			1	795	925
50.00%	**69.23%**	**N/A**	**N/A**	**0.00%**	**51.07%**	**87.03%**

0	7	0	1	0	754	1214
1	19	1	1	11	826	1255
0.00%	**36.84%**	**0.00%**	**100.00%**	**0.00%**	**91.28%**	**96.73%**

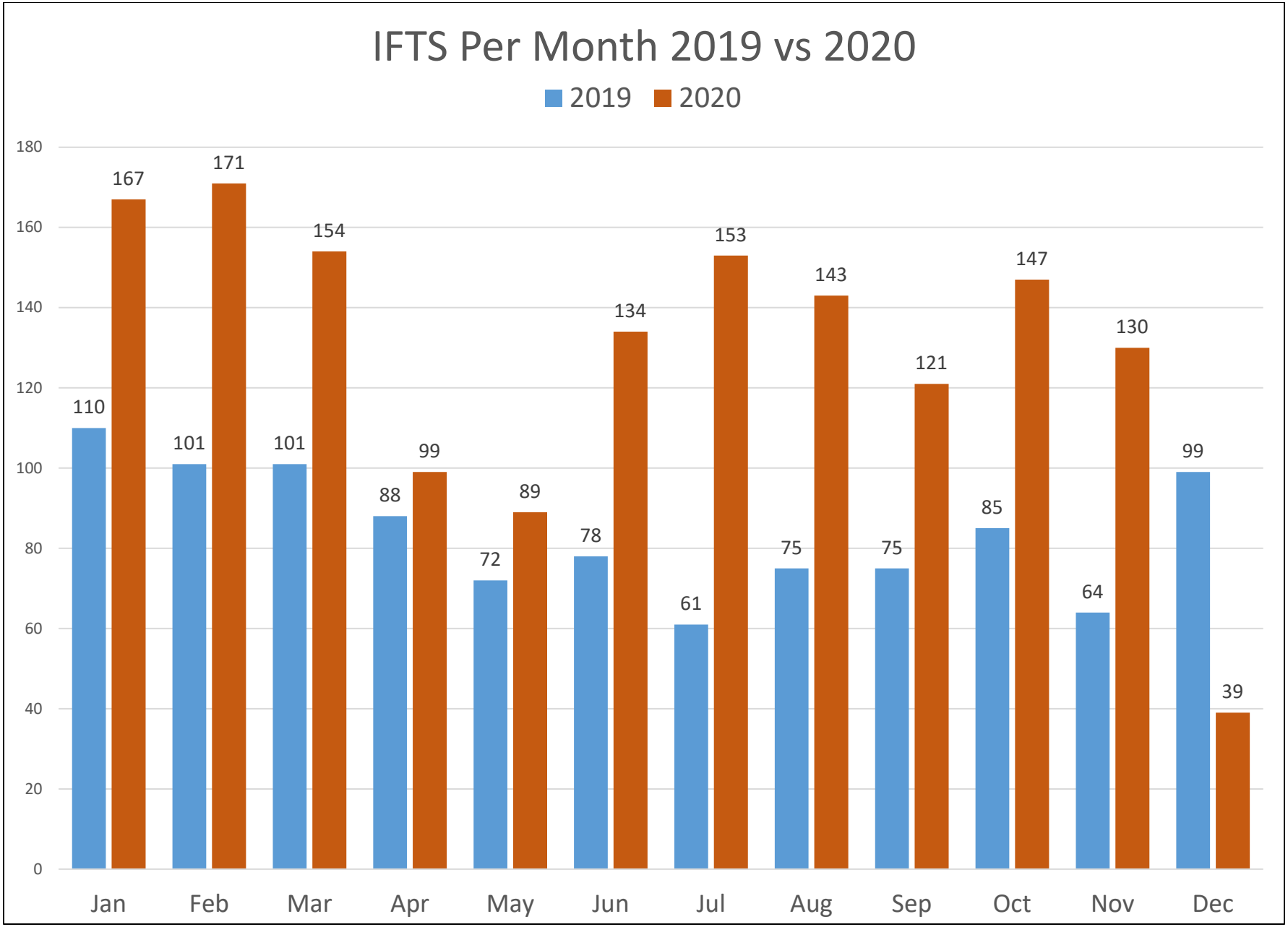
0	3	0	0	7	26	1
1	19	1	1	11	826	1255
0.00%	**15.79%**	**0.00%**	**0.00%**	**63.64%**	**3.15%**	**0.08%**

	3				172	892
	4		1		192	986
N/A	**75.00%**	**N/A**	**0.00%**	**N/A**	**89.58%**	**90.47%**

0	11	0	0	0	108	171
0	12	0	0	1	113	187
N/A	**91.67%**	**N/A**	**N/A**	**0.00%**	**95.58%**	**91.44%**

	SCEMSA
0	395
24	2932
0.00%	13.47%
9	4998
16	6402
56.25%	78.07%
0	262
2	710
0.00%	36.90%
2	1575
6	2214
33.33%	71.14%
10	2756
12	3042
83.33%	90.60%
8	204
12	3042
66.67%	6.71%
	1530
8	1708
0.00%	89.58%
2	406
2	437
100.00%	92.91%

Original Report
Generated as written. No


IFTS Per Month 2019 vs 2020
2019
2020
180
160
140
120
100
80
60
40
20
0
110
167
101
171
101
154
88
99
72
89
78
134
61
153
75
143
75
121
85
147
64
130
99
39
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec

July SCEMSA	Provider	Difference	Missing Percent	August SCEMSA	Provider2	Difference 3	Missing Percent 2	September SCEMSA	Provider	Difference	Missing Percent 3
1,434	2,085	651	31.22%	1,571	2,187	616	28.17%	1,604	2,338	734	31.39%
242	300	58	19.33%	195	245	50	20.41%	141	238	97	40.76%
1,940	1,944	4	0.21%	2,001	1,998	-3	-0.15%	1,953	1,954	1	0.05%
228	220	-8	-3.64%	217	218	1	0.46%	253	240	-13	-5.42%
3	8	5	62.50%	7	7	0	0.00%	3	8	5	62.50%
1,401	1,451	50	3.45%	1,464	1,502	38	2.53%	1,303	1,353	50	3.70%
202	485	283	58.35%	172	469	297	63.33%	194	486	292	60.08%
1,459	1,560	101	6.47%	1,266	1,484	218	14.69%	1383	1713	330	19.26%
1,449	1,483	34	2.29%	1,400	1,447	47	3.25%	967	1468	501	34.13%
438	733	295	40.25%	489	678	189	27.88%	619	751	132	17.58%
6,357	6,346	-11	-0.17%	6,620	6,589	-31	-0.47%	6,196	6,232	36	0.58%
7,043	6,936	-107	-1.54%	7,227	7,066	-161	-2.28%	6,722	6,683	-39	-0.58%
198	216	18	8.33%	245	270	25	9.26%	276	276	0	0.00%
29	31	2	6.45%	18	19	1	5.26%	39	41	2	4.88%