Sacramento County Emergency Medical Services Agency (SCEMSA)
Joint Medical Advisory (MAC)/Operational Advisory (OAC) Committees

9616 Micron Ave. Suite 940
Sacramento, CA. 95827
September 11, 2025

Agency	Representative
AirLife	Neveen Sharkawy
AlphaOne Ambulance	Matt Burruel
AMR	Arlen Soghomonians Justin Begley Dean Torgerson
Boundtree	Eddie McThorn
Cosumnes Fire Department	Tressa Naik Julie Carrington
EDC JPA	Hope Youngblood
Folsom Fire	Brian Sloane
Hospital Council	Brian Jensen
Kaiser	Rich Meidinger Greg Smith Sarah Henry Rachel Wyat Joanthan Hartman Chris Britton Pat Zvelak
Mercy General	Najwa Green Jennifer Ault-Riche Theresa Hernandez
Mercy San Juan	Terry Hiddell
Methodist	Krystyna Ongjoro
NorCal Ambulance	Alastair Lavin Nic Scher
Sacramento City Fire Department	Brian Morr Kevin Mackey
Sacramento Metro Fire Department	Alex Schmalz Adam Blitz Dylan Hurley Scott Perryman
UC Davis Medical Center	Jeremy Veldstra
Wilton Fire	Rodrick Huerta-Moore

ITEM	ACTION	DETAILS
Welcome and Introductions	**None**	**None**
Minutes Review	June 12, 2025	**Approved:** Adam Blitz & Terry Liddell
New Business: **PD# 8060** – Stroke	**Proposed changes:** 1. If CPSS is > 0, and "last seen normal" *time, including wake-up Stroke, is twenty-four (24) hours or less, ~~the patient is to be taken to a~~	• Proposed using LAMS score to identify large vessel occlusive (LVO) strokes • Focuses on patients outside thrombolytic window

	~~certified stroke center.~~ perform Los Angeles Motor Score (LAMS): a. LAMS Scoring: i. Facial Droop: Absent = 0, Present = 1 ii. Arm Weakness: Absent = 0, Drifts = 1, Falls Rapidly = 2 iii. Grip Strength: Equal = 0, Weak = 1, No Grip = 2 iv. Total Score Range: 0–5 b. LAMS score ≤ 3 transport to closest **Stroke Receiving Center** c. Transport to a ***Comprehensive Stroke Center (CSC) if:** i. Travel time ≤ 30 minutes AND ii. LAMS score ≥ 4 AND iii. LKWT is ≥ 4.5 hours OR meets any of the following contraindications to lytics: • ~~No~~ History of Intracranial Hemorrhage • ~~No~~ History of stroke within the past 3 months • ~~Not~~ Actively taking anticoagulations	• Aims to direct patients with LAMS score 4-5 to comprehensive care • Extended public comment period • Final decision to be made in November
PD# 2030 – ALS Inventories	**Not approved**	• Remove specific brand names for medical equipment • Everyone agrees it will allow more flexibility in equipment selection • If the brand name was removed, it would require proper training for new equipment • Emphasize standardization while allowing innovation • SCEMSA is in favor of removing specific brand names for supraglottic airways however our current LOSOP with EMSA is specific to Pediatric IGELS. We will

		contact EMSA to see if we can remove the brand name from the supraglottic airway
PD# 2525 – Prehospital Notification	**Approved with changes** 1. Clearly announce any hospital pre-arrival alert or notification: a. Trauma alert: • Criteria and mechanism of injury • Patient's name, date of birth, or medical record number, if known. b. Stroke : • "Last time of day observed to be normal" reported by bystanders. • Patient's name, date of birth, or medical record number, if known. • Baseline Mental Status (GCS) c. STEMI: • Transmit 12-Lead as soon as practible • Patient's name, date of birth, or medical record number, if known. • Whenever possible, STEMI alerts should be communicated within 10 minutes of a positive STEMI recognition d. Sepsis Alert: • Pre-hospital fluid resuscitation, temperature e. Cardiac Arrest: • Patient meets cardiac arrest protocol, resulting in the selection of a PCI, or closest receiving facility. 2. Patient age and gender. 3. Chief complaint (include mechanism of injury or nature of illness). 4. Brief pertinent history. 5. Full set of current and~~/or~~ previously pertinent abnormal vital signs.	• Clarify reporting requirements for trauma and STEMI alerts • Standardize vital sign reporting • Ensure early notification of critical patients • Simplify communication protocols

PD# 5011 – Paramedic/AEMT to EMT Transfer of Care	**Approved with changes** A. Paramedics can transfer care to an EMT for stable ~~low-acuity~~ patients meeting all the following criteria: ~~1. Oriented to person, place, time with a GCS of 15 and must exhibit decision-making capacity, unless there is a history of dementia with caregiver verification of baseline mental status.~~ Patient GCS ≥ 14 or at baseline mentation if the baseline is less than 14. ~~2. Exhibit no evidence of altered level of consciousness or be under the influence of drugs, alcohol, or other substances.~~ 3. No new focal weakness, dizziness/vertigo or seizure activity. 4. Systolic blood pressure: sBP ≥ ~~90~~ 100 mmHg or ≤ 200 mmHg. 5. Diastolic blood pressure: dBP < 120 mm Hg. 6. Heart rate: HR > 50 or < ~~120~~ 110. 7. Respiratory rate: RR > 10 or <~~24~~ 20. 8. O2 saturation ≥ 94%. O2 saturation for COPD patients ≥ 88% or patient stable on home oxygen level. B. Paramedics **CAN NOT** transfer care to an EMT for any patient meeting the following criteria: 1. Any patient meeting trauma criteria per PD # 5053 – Trauma Triage Criteria. 2. ~~Have syncope, or~~ Brief resolved unexplained event (BRUE) ~~3. Active chest pain or meet~~ ~~Anyone with an EKG reading STEMI~~ Any patient with chest pain of suspected cardiac origin ~~criteria~~	• Clarify conditions for transferring patient care • Standardize vital sign parameters • Separate clinical and operational aspects of policy • Improve clarity for field providers

	~~per PD# 8030 – Discomfort/Pain of Suspected Cardiac Origin.~~ 4. Positive stroke assessment per PD# 8060 - Stroke. 5. Combative or currently under chemical and/or physical restraint. 6. Suspicion for ingestion or overdose and unable to maintain airway. 7. Airway support (BVM, NIV).	
PD# 7508 – SALT	April 1, 2026	MCI Plan Nov 1st with mention of both START/SALT. SALT set to go live April 1, 2026.
PD# 8028 – Environmental Emergencies	**Approved**	No comments
PD# 8042 – Child Birth and Obstetric Emergencies	**Approved with changes** **Post-Partum Care** • For eclamptic seizure, refer to PD# 8003 – Seizures • For uncontrolled, postpartum hemorrhage: -Administer 2gm TXA slow IV/IO push over 1 minute	• Update policy name • Include midwife collaboration guidelines • Add preeclampsia care protocols • Incorporate magnesium administration guidelines • Add tranexamic acid for postpartum hemorrhage
Scheduled Updates **PD# 2002** – Naloxone Leave Behind	**Approved with changes** a. ~~Department of Health Services~~ Opioid resource information sheet.	• Change current verbiage in policy to "Opiod Resource Information Sheet". Everyone agreed.
PD# 2003 – BLS Tiered Response System	~~1. Potentially unstable adult patient:~~ ~~a. Cardiac Arrest.~~ ~~b. Heart Rate < 50 or > 120.~~ ~~c. Systolic Blood Pressure < 90mmHg.~~ ~~d. Respiratory Rate > 24.~~ ~~e. 0_2 sat < 94% (88% for COPD patients) if the patient is on home oxygen, as measured by usual oxygen flow rate.~~ ~~f. Any patient that meets trauma activation criteria.~~ ~~2. Potentially unstable pediatric patient: Pediatric patients will be evaluated using the Pediatric~~	• No need to describe the unstable patient

	~~Assessment Tool (PAT). This tool assesses the patient, under the age of 14, according to the following three components: appearance, work of breathing, and circulation.~~ ~~a. Appearance: Using the mnemonic TICLS. The patient is unstable if there is any abnormality of the following.~~ ~~• Tone.~~ ~~• Interactiveness.~~ ~~• Consolability.~~ ~~• Look/gaze.~~ ~~• Speech/Cry.~~ ~~b. Work of Breathing: The presence of any of the following implies abnormal work of breath and, therefore, potential instability.~~ ~~• Stridor.~~ ~~• Wheezing.~~ ~~• Grunting.~~ ~~• Tripod positioning.~~ ~~• Retractions.~~ ~~• Nasal flaring.~~ ~~• Apnea/gasping.~~ ~~c. Circulation of the Skin: The presence of any of the following indicates abnormal circulation or poor perfusion.~~ ~~• Pale.~~ ~~• Mottled.~~ ~~• Cyanotic.~~ ~~B. Failing any one point within the three components of the PAT assessment will indicate a potentially unstable pediatric patient and therefore necessitate an ALS level of response.~~	
PD# 2004 – Patient Privacy	**Approved**	No comments
PD# 2007 – Trauma Hospital Data Elements	**Approved with changes** Data shall be submitted no later than 90 days following the end of the quarter. Non-compliance with the data requirements can lead to program suspension	• 90 days for data submission was agreed upon at the last Trauma Improvement Committee meeting.
PD# 2010 – Medical Advisory Committee	**Approved**	No comments

PD# 2020 – Operational Advisory Committee	**Approved**	No comments
PD# 2026 – Trauma Improvement Committee	**Approved**	No comments
PD# 2500 – EMS Aircraft Designation Requirements	**Approved**	No comments
PD# 2510 – Designation Requirements for Ground Based ALS Service Providers	**Approved**	No comments
PD# 2520 – Hospital Emergency Service Downgrade or Closure Impact Evaluation Report	**Approved**	No comments
PD# 4003 – Emergency Medical Services Liaison	**Approved**	No comments
PD# 4050 – Certification-Accreditation Review Process	**Not Approved**	• SCEMSA must follow up with EMSA to see if current language is appropriate
PD# 4055 – Criminal Background Checks	**Approved**	No comments
PD# 4303 – EMR Program Requirements and Approval	**Approved**	No comments
PD# 8025 – Burns	**Approved with changes** 4. Whenever possible, this should be completed prior to transport. a. It is critical that providers remain on scene to complete a full 20 minutes of continuous cooling with running water before initiating transport unless the scene becomes unsafe or the patient's condition necessitates immediate transport. ~~b. Early cessation of cooling may lead to worsened burn severity and increased tissue damage. If transport is initiated before 20 minutes of cooling is completed, cooling should~~	• Clarify continuous cooling water requirements • Discussion about how much fluid to give base on surface area burned • Simplify language about burn surface area treatment

	~~continue en route whenever feasible.~~ 5. After cooling the burn, apply a covering to the burn (dry non-stick gauze, loose plastic wrap, etc.) 6. Avoid hypothermia by isolating and cooling only the burned area. Keep unaffected body parts warm by covering them as much as possible, and use the heater in the passenger compartment. ALS 3.Initiate large bore vascular access in patients with major burns (>9%). • Titrate to systolic blood pressure of ≥ 90 mmHg. • Administer 500 ml normal saline fluid bolus to all adult patients ~~with a Total Body Surface Area (TBSA) of burns ≥ 50%~~ • When possible the preferred vascular access site is an unburned area. ~~Pain Management: If partial or full thickness burn with moderate to severe pain and without evidence of or mechanism of internal head, chest, or abdominal injury,~~	
PD# 9006 – Pediatric Medical Cardiac Arrest	**Approved with changes** Pediatric Cardiac Arrest Assess for responsiveness, spontaneous respirations, and pulses and no obvious signs of death per PD#2033 Patients in refractory VF/pulseless VT at 15 minutes ~~>>>>>>>>>>>>>>>>>>>>~~, should be transported to the closest receiving center	• Clarify that all pediatrics get transported to the ED after 20 minutes of ALS CPR • Discuss epinephrine dosing limitations • Add language about obvious signs of death • Provide guidance on resuscitation efforts
PD# 9007 – Pediatric Diabetic Emergencies	**Approved**	No comments
PD# 9008 – Pediatric Seizures	**Approved**	No comments

PD# 9009 – Pediatric Neonatal Resuscitation	**Approved with changes** NOTE: Clinical viability is generally defined as beginning at 22-23 weeks gestation, however the provider shall use medical discretion when providing care.	• Provide general guidelines for viability • Avoid strict cutoff ages • Emphasize medical discretion
PD# 9011 – Pediatric Overdose	**Approved**	No comments
Chairman's Report	Declared APOT Emergency memo	• Establish procedure for low ambulance unit scenarios • Create mechanism to release hospital-held ambulances • Improve system-wide communication • Maintain public safety during critical resource shortages
Roundtable		
Adjournment	**Next MAC/OAC December 11, 2025, at 9616 Micron Ave**	