

**Sacramento County**  
**Department of Health and Human Services - Emergency Medical Services Agency**  
**Joint Medical Oversight (MOC)/Operational Oversight (OOC) Committees**  
**9616 Micron Ave. Suite 960**  
**Sacramento, CA. 95827**  
**September 8, 2016**

**Facilitator:** Hernando Garzon, M.D. SCEMSA Medical Director

**Scribe:** Veronica Kennedy and Petrus VanNiekerk EMS Specialist II

**Meeting Attendees MOC:**

- Ric Maloney, RN Sacramento Metropolitan Fire Department
- Nathan Beckerman, M.D. Mercy San Juan Medical Center
- John Rose, M.D. UC Davis Medical Center
- Lee Welter, M.D. Sierra Sacramento Valley Medical Society; ECC
- David Shatz, M.D. Sacramento Metropolitan Fire Department
- EMS Staff

**Meeting Attendees OOC:**

- Jon Brooks, NorCal Ambulance
- Chad Augustin, Sacramento City Fire Department
- Matthew BurrueI, AlphaOne Ambulance
- Brian Gonsalves, Sacramento Metro Fire 9-1-1 Rep
- Hillary Mitchell, R.N. Kaiser South Sacramento
- Mark Piacentini, Folsom Fire Department
- Julie Carrington, Cosumnes Fire Department
- Jennifer Bales, American Medical Response Ambulance
- Joe Thuesen, Sacramento Regional Fire/EMS Communication Center
- Brett Shurr, Cosumnes Fire Department
- Adam Blitz- American Medical Response Ambulance
- Devon Luce, ProTransport-1
- Wendin Gulbransen, Kaiser South Sacramento
- Jennifer Bales, American Medical Response Ambulance
- Barbie Law, Sacramento Metropolitan Fire Department

- Jacqueline Pera, Mercy San Juan Medical Center
- Maurice Johnson, Sacramento Metropolitan Fire Department
- David Buettner, UC Davis Medical Center
- EMS Staff

**Guest:**

- Christy Jorgensen, Cascade Training Center
- Jack Philp, Sacramento County Dept. Airports Aircraft Rescue Firefighting
- Patricio Beklin, TLC Ambulance
- Greg Gaughan, First Responder EMS
- James Macadangdang, NorCal Ambulance
- Ken Bradford, Falck
- Jason Baldwin, Sacramento Metropolitan Fire Department
- Tracey Valentine, Sacramento Metropolitan Fire Department
- Mark Dunne, Sacramento Metropolitan Fire Department
- David Warren, Sacramento Resident

- **Minutes Approved July 14, 2016:** - Dr. Garzon, SCEMSA Medical Director- Chairman - **APPROVED**

Topic	Minutes
Welcome and Introductions	<b>Chairman’s Report: None</b>
Public Comment	<p>Dr. Garzon recaps Policy 5050-Destination and Mr. David Warren’s concerns regarding the policy. SCEMSA pulled the policy out of turn to review today after hearing from Mr. Warren and the committee’s comments. The committee is reviewing whether the policy adequately gives direction to paramedics for destination decisions. Sacramento resident, Mr. Warren, attended the meeting to discuss his request that the SCEMSA consider amending policy 5050. Mr. Warren’s letter detailing his request was distributed in advance to all committee members for review. Mr. Warren’s letter is attached to these minutes as an addendum.</p> <p>Mr. Warren addresses the committee: Mr. Warren begins with stating he suffers from Atrial Fibrillation and as recently as eight (8) weeks ago. When Sacramento Metropolitan Fire treated and transported him, it was determined he suffered a</p>

Topic	Minutes
	<p>transient ischemic attack (TIA) which was diagnosed by MRI at UC Davis. Mr. Warren states, due to his age and past medical history, he is at high risk for strokes. Mr. Warren states the best diagnostic tool for him is an MRI to see if he has an occlusion or a hemorrhage. Mr. Warren states he understands, from talking with numerous paramedics, that Sacramento County has many people who abuse the system, but many individuals, have specific medical issues that can only be addressed at certain hospitals. Mr. Warren states he has been to Mercy San Juan Medical Center (MSJ) on several occasions and has been informed by MSJ emergency room staff that an MRI is not available because of his pacemaker. Mr. Warren does have a pacemaker that is compatible with MRIs. Mr. Warren states his situation is simple, he recognizes there is a risk with transportation time, but there's also a risk associated with the fact that he cannot obtain a proper diagnosis at the closest hospital to his residence, which is MSJ. The solution, Mr. Warren states, is for people to have the ability to have informed consent; that the paramedic should be able to use their judgement to allow transport to a hospital that can provide the proper diagnostic tools. Mr. Warren recognizes the difficulty paramedic's face and he has placed his medical diagnosis, directive, needs for transportation and medication list on his door, so if the paramedics arrive and Mr. Warren is unconscious, they have his information. Mr. Warren wears a bracelet with his medical history and medications. Mr. Warren believes he has done everything possible to make it easy on the paramedics to do what they have to do. Mr. Warren recognizes that certain times of day aren't feasible for transportation to UC Davis because it would be a two (2) hour drive, but at seven (7) pm or on a Sunday afternoon, then the best place for him is UC Davis, not MSJ. Mr. Warren states he has had several conversations with Dr. Cooperman and Dr. Lavarano at UC Davis and they will make sure if he were to arrive at UC Davis, he would receive the proper treatment. The piece of the puzzle that needs to be changed, per Mr. Warren is Policy 5050. Mr. Warren provided proposed language for the exception and he recognizes that this could be problematic and proposes that a form be made that allows for the patients to, upon application of medical need, removing the liability of paramedics and the medical staff, to allow patients with special medical needs, to make informed consent decisions. Mr. Warren asks that SCEMSA and the MOC/OOC members add or amend the current Policy 5050- Destination to allow for individuals with specific medical needs which cannot be met at the closest medical facility to be transported to the closest medical facility that can provide the diagnostic tools.</p> <p>Dr. Hernando Garzon thanks Mr. Warren and states that as part of the process for this, Dr. Rose and Dr. Beckerman spoke to the radiological departments at their respective facilities and Dr. Garzon has spoken to a number of neurologist and experts in care for strokes and the standard of care is not MRI imaging for the management of emergency strokes. In particular, the UC Davis radiologist mentioned that if they go beyond CT scanning, its usually CT and geography and that even in Mr. Warrens case because of the pacemaker, UC Davis can do it, but it's complicated, and there has to be a physician monitoring it and on the scene. It is nothing they do emergently. The statement that MSJ cannot provide the emergency care and</p>

Topic	Minutes
	<p>stabilization for stroke is not accurate. MSJ is the only comprehensive stroke center in Sacramento, meaning are certified at a higher level than other stroke centers, including UC Davis.</p> <p>Comments from MOC/OOC committee:</p> <p>*Dr. Shatz-We already allow patients to direct destination if it isn't life threatening, so adding more language wouldn't change that, and does agree with the comments that using an MRI for emergent diagnostic evaluation for strokes; hemorrhagic vs occlusive is not done regularly. Dr. Shatz doesn't believe adding additional language will help and believes if Mr. Warren wanted to go to UC Davis, which the paramedics wouldn't object to it, unless they had a concern.</p> <p>*Maurice Johnson- It depends on what the patient presents with because current policy, depending on patient status, will dictate where the patient has to go.</p> <p>Chief Johnson believes that is where the concern is, Mr. Warren wants to go to UC Davis, where in the policy, it doesn't allow for that given Mr. Warren's current status, because it could be cardiac in nature or potential stroke.</p> <p>*Dr. Garzon-Just a reminder; the way the policy is designed, is that the most important priority in determining a destination is the criticality of the patient. Do they have trauma that meets trauma center criteria or is it a cardiac arrest, or is it something that merits time closest hospital, or is it a specialty service, like burns or strokes? Medical evidence shows that patients do better by taking them to those specialty centers. If there isn't one of those priorities then the second level is patient discretion and where they would like to go. In Mr. Warren's case, all three (3) of his transports were reviewed, and we found that he was hypotensive and actively having chest pain and qualified by medical criteria for time closest hospital, that could take care of both the possibility of a cardiac event and/or stroke. In all cases, the paramedics have done the right thing by taking Mr. Warren to the time closest emergency room as Policy 5050 states under special triage policies.</p> <p>*Barbie Law- Mr. Warren's concern is already addressed in protocol because we have a specific caveat that, in Ms. Law's opinion, if the patient's condition is unstable and they want to go to their own designation it specifically directs us to make base contact to arrive at the most appropriate destination decision and consult with a physician on that, so that section is already in the protocol. Ms. Law states there is nothing that says paramedics have to go to the closest facility, there are other options and procedures to go through.</p> <p>*Dr. Garzon believes that the consensus in the room and consultation with medical staff at MSJ and UCD indicate no support to amend policy 5050, and that the policy currently meets standard of care in EMS to deliver EMS patients to appropriate facilities, including in Mr. Warren's case." Dr. Garzon asks if there are any further comments regarding amending the policy. No response.</p> <p>Dr. Lee Welter- Regardless how we resolve this potential conflict, he wishes we had more people who were as articulate and thoughtful as Mr. Warren. Dr. Welter appreciates and thanks Mr. Warren.</p>

Topic	Minutes
	Dr. Garzon states policy will stand and it will come around again when it's due for review 01/01/18.
Supplemental Old / New Business	<p><b>Medication Shortage/Updates:</b> High dose epi (multi-dose epi) is difficult to get a hold of, still there but can't get it in the normal batch; they have to buy something different, not affecting them currently.</p> <p><b>Wall times:</b> No updates.</p> <p><b>New Business:</b></p> <ul style="list-style-type: none"> <li>• <u>EMS Reporting</u>-SCEMSA added an EMS Events page to the SCEMSA website for reporting concerns, compliments, provide information to us. Ben Merin demonstrates where it is on webpage and how to fill it out. It is a HIPPA compliant form. Form goes to Veronica Kennedy. Maurice Johnson asks; who's the audience and what's the purpose? Ben Merin states, the audience is the community, providers, hospitals and the purpose is for people to be able to communicate directly to the EMS Agency. In return, the sender gets an automatic email time stamped and dated for their files. This form on SCEMSA website is an option, not mandatory to use.</li> <li>• <u>MCI Reporting/Critique forms:</u> Critique forms are now available on the SCEMSA website and are automatic and easily emailed so we have better reporting/data capability. Contains all the same information as the printable forms. We can build it out to where the person sending the MCI Critique can automatically receive a copy of it once they hit send. It is not mandatory to fill it out from SCEMSA website you can still print it out and send it in as currently done.</li> <li>• <u>Dr. Garzon introduces Dr. Daniel Nishijima- Head Injury Study from UC Davis-</u> most of his research has been on traumatic brain injuries and anticoagulants. Dr. Nishijima discusses some research and studies recently done and up and coming studies. Talked about four (4) different projects: <ol style="list-style-type: none"> <li>1. Older adults and head trauma, particularly those taking anticoagulants. A cooperative agreement between UC Davis and the CDC. Project began in December 2012 and completed in August 2016.</li> <li>2. Working with Sacramento City on Pediatric Emergency Care Applied Research Network (PECARN). The mandate from the Health and Human Services is that there needs to be more pre-hospital pediatric research.</li> <li>3. Pediatric Trauma Triage study- Objective is to improve pediatric trauma triage.</li> <li>4. NIH emergency care research network (SIREN). Conduct phase three trials, where a drug or intervention is done and followed. One of these trails (Trauma/pre-hospital/cardio/pulmonary trail) will be pre-hospital if they are chosen to do the study. There are 21 sites within Sacramento County from community hospitals to academic centers involved in this potential study</li> </ol> </li> </ul>

Topic	Minutes
	<p><b>PD# 2501- Emergency Medical Dispatch Priority Reference System (EMDPRS) - NEW</b> – Policy has been amended based on feedback already received and some comments came in yesterday from fire dispatch which fell outside comment window so SCEMSA has not had time to review those comments yet but SCEMSA would like to look at those for possible further edits to policy.</p> <p><b>Airport Fire</b> had some concerns- wanted to clarify that any dispatching agency that dispatched medical calls had to follow this policy and if so will there be a grace period to allow for training? Maurice Johnson states the Airport Fire dispatch is handled through the Fire dispatch center, a dual dispatch system that ties in with Sacramento Fire dispatch center.</p> <p><b>Tabled</b> until November.</p> <p><b>PD# 8062- Behavioral Crisis-Restraint – Approved</b> as on website</p> <p><b>PD# 8802- Intraosseous Infusion – Approved – with</b> minor edits</p>
<p>Scheduled Program Documents for Review</p>	<p><b>PD# 8001– Allergic Reaction Anaphylaxis- Approved</b></p> <p><b>PD# 8020- Respiratory Distress-Airway Management – Approved-</b> Discussion around nasal intubation or RSI-Dr. Garzon states adding it back would be a matter of need and data that shows the need. Is nasal intubation wanted by all providers or just a couple? RSI would involve a lot of training. Once you go down the path of RSI there is no going back.</p> <p><b>PD# 8026- Respiratory Distress - Approved</b> with edits</p> <p><b>PD# 8027- Nerve Agent Exposure- Approved</b></p> <p><b>PD# 8801- Cricothyrotomy, Needle with Jet Insufflation – Approved-</b> Bring back in November to look at QuickTrach</p> <p><b>PD# 8805- Intubation-Stomal - Approved</b></p> <p><b>PD# 8825- Esophageal Tracheal Intubation - Approved</b></p> <p><b>PD# 8826- Medication Administration, MARK I Nerve Agent Antidote Kit- Approved to be deleted</b></p> <p><b>PD# 8829- Continuous Positive Airway Pressure (CPAP)- Tabled</b> until November</p> <p><b>PD# 8833- Ventricular Assist Device (VAD) – Tabled</b> until November- Contact VAD specialist/cardiologist to make recommendations regarding ASA and/or nitro in C/P.</p>
<p>New Topics</p>	<p>NONE</p>

Topic	Minutes
Roundtable	<ul style="list-style-type: none"> <li>• Dr. Shatz talked about traumatic arrest and using needle decompression and the protocols for that. At the Regional Trauma Committee, they had a medical director from the State of Oregon come down, and they use a trauma band on every trauma patients wrist for tracking (band has tracking numbers), which gives you from field to ER to hospital discharge and it goes into Oregon’s state registry for data collection. They are working on putting this into effect in Northern California. Pre-hospital puts them on every trauma patient and the state pays for them.</li> <li>• Maurice Johnson- Metro Fire along with the FBI and State Attorney’s office is putting on a class on human trafficking and first responders on September 13<sup>th</sup> 0900-1200.</li> <li>• Wendin Gulbransen– Clarification on Trauma Triage Criteria regarding Pediatric patients. Wendin uses example of an adult in an auto accident and under the mechanism piece it states; “they shall have an injury or complaint,” and in that car you have a pediatric patient with the adult. The box on right hand side states; “pts less than or equal to 14 yrs. of age will be transported if they meet the following conditions..” Wendin states she is seeing this lately where you have a kid who is two (2) years old or less, who can’t tell you if they have a complaint being transported with the parent. Wendin’s concerns are about destination. Kaiser South is not a pediatric hospital. You have adults in a severe vehicle accident who are designated to a trauma hospital and the kids meet trauma destination, but are coming in as a whole family because the kid can’t vocalize a complaint.</li> <li>• David Buettner and Dr. Rose, state the paramedics should be calling UC Davis and UC Davis would direct the field personnel to come to UC Davis.</li> <li>• Wendin Gulbransen is seeing a trend on the above scenario and is concerned there is confusion over how the policy is written.</li> <li>• Dr. Garzon thinks this is an educational piece for the paramedics and these cases should be referred to the agency/provider.</li> <li>• Dr. Rose announced that he will still be part of the MOC/OOC committee representing UC Davis but he is now the medical director for Yolo County EMS.</li> <li>• Ben Merin, talked to various groups over last 8-10 months about patient tracking in MCIs and how we will track patients in disasters throughout the county. SCEMSA owns EMTrack, another Intermedix product under EMResource. We now have a functional patient tracking system built, ready to go, from EMS in the field to discharge from the EDs. We can track a single patient from multiple events. Ben Merin will be contacting the hospitals to test it in a live event, CIM, December 4<sup>th</sup> (only tracking patients that are injured at the marathon, not all runners; however every participant will be in the database). Prior to December 4<sup>th</sup>, Ben Merin is looking for hospital participation and</li> </ul>

Topic	Minutes
	<p>commitment to tracking a patient injured that day through EMTrack through discharge so he can get a true test of the system. He wants time prior to December 4, 2016 to train the hospital staff. Ben Merin to send out email to hospitals.</p> <ul style="list-style-type: none"> <li>Lee Welter- Recognizing that simulation is a valuable tool in EMS education as a way to maintain skills. ARC is expanding the scope of availability of its simulation lab and making it available to the county. Unknown to specifics on cost if there were a cost.</li> </ul>
Adjournment	Meeting adjourned at 11:20am

**Minutes Distribution:** Minutes posted on Sacramento County Emergency Medical Services Agency Website prior to meeting for review

**Next Meeting: November 10, 2016**

Action Item	Assignee	Due Date	Completed
<ul style="list-style-type: none"> <li>Obtain a QuickTrach for review</li> </ul>	SCEMSA Staff		In process
<ul style="list-style-type: none"> <li>Contact VAD specialist regarding administration of ASA/Nitro</li> </ul>	SCEMSA Staff		10/4/16
<ul style="list-style-type: none"> <li>Ben Merin to send email to hospitals to participate in EMTrack</li> </ul>	Ben Merin		



DAVID WARREN  
7000 San Felipe Ct.  
Citrus Heights, CA 95621  
Telephone: (916) 729-1635  
Cellular Telephone: (916) 203-3000  
Fax: (916) 727-0472  
Internet: DavidWarren2@msn.com

5 August 2016

Hernando Garzon, M.D.  
EMS Medical Director  
Emergency Medical Services  
9616 Micron Avenue Suite 960  
Sacramento, CA 95827

Re: Presentation at the MOC/OOC September meeting re: MOC/OOC  
Document 5050.13 as amended

Doctor Garzon:

I request that this document be included for consideration with the packet of information that is distributed to those individuals that decide policy and my request for amendment to MOC/OOC Document 5050.13 effective date 1 May 2016. At the September meeting, I am requesting that the MOC/OOC amend the protocol provided in the attached addendum be amended as suggested in sections "*B:1- 2 and J.*" As you may note from my address, Mercy San Juan Hospital is the designated medical facility pursuant to Document 5050.13 for emergent medical need when I am in my home.

I suffer from Atrial fibrillation (A-fib) which is typically controlled via extended release Diltiazem. I also have an internal pacemaker which is magnetic resonance imaging (MRI) compliant, i.e., I may undergo an MRI without risk to myself or the pacemaker after the manufacturer technician (available 24/7 in Sacramento) adjusts the pacemaker for the MRI examination.<sup>1</sup> The importance of access to MRI diagnosis is self-evident as the best diagnostic tool to determine whether I have suffered an intracranial hemorrhage or hematoma as a consequence of the A-fib, or other cause. Early implanted pacemaker versions were not MRI safe, i.e., any attempt to use an MRI would cause the magnet to pull the pacemaker out of the chest. Advanced pacemakers such as the one I use are MRI safe, and both UC Davis and Sutter Hospitals will use an MRI. The risk to me if the emergency room medical staff reaches an erroneous

---

<sup>1</sup> Biotronic, the pacemaker manufacturer, has technicians available 24/7 in the Sacramento metropolitan area available to respond within a one-hour window.

diagnostic conclusion for treatment is obvious. Mercy San Juan Hospital is the medical facility to which Doc. 5050.13 mandates I be transported if I present symptoms of either A-Fib or stroke.

I have had to be transported for A-Fib three times. Each time I requested that I be transported to the UC Davis Medical Centre, not because I am a difficult patient, but rather because UC Davis will perform an MRI should it be deemed medically necessary. Mercy San Juan Radiology will not perform a MRI because of my pacemaker, regardless of the fact that my particular pacemaker is FDA approved for an MRI.

The obvious risk associated with A-Fib is Acute Stroke. The AHA/ASA Guidelines for Acute Stroke Treatment published 31 January 2013 indicate that door to needle should be completed within 60 minutes. Although a computerized tomography (CT) scan is helpful, it is not definitive stroke diagnosis. If an MRI should be required, the delay in having me transported from Mercy San Juan Hospital to UC Davis Medical Centre could be either life threatening or altering. The appropriate treatment for stroke is administration of tPA (tissue-type plasminogen activator) within 6 hours of the stroke followed by a proximal large vessel thrombectomy if the tPA fails to clear the clot as based upon a biplane 3D image. If appropriate treatment for a cerebral hemorrhage is the exact opposite, i.e., surgery if possible to cauterize the bleeding point. The treatments are mutually exclusive because if tPA is introduced if I am suffering a cerebral hemorrhage, it will aggravate the bleeding and likely lead to my death.

I am seeking your assistance for reasonable medical necessity. Although there are undoubtedly patients which are difficult to manage and/or ill-informed of risk, both my wife and I fully comprehend the risk associated with transportation to a more distant medical facility if I have an abnormal sinus rhythm and the related symptoms of stroke or hemorrhage. I am sufficiently educated, i.e., two law degrees and two Ph.Ds. in economics, as well as familiar with electrophysiology because my brother was formerly the president of Guidant pacemaker division, with whom I had dealings on his behalf, to make an informed decision for a hospital designation. My wife is a retired clinical dietician. Both I and my wife, via medical directive, are sufficiently knowledgeable and competent to make the risk assessment of travel time for treatment to be able to provide informed consent to the EMTs who will provide the transportation against their advice.

It should be self-evident that should a medical incident occur during a period of travel difficulty (such as rush hour), significant demand for emergency services, or public emergency that a request for transportation to UC Davis would be moot. However, as a patient, I should not be faced with the decision of calling a taxi to drive me to UC Davis Medical Centre rather than being transported under supervision by a Metropolitan Fire Department EMT because of the refusal to transport to UC Davis Medical Centre solely because of a preset parameter set

forth in Document 50-50.13 which does not take into consideration individual needs.

In making the decision to direct the EMS technicians to bypass Mercy San Juan Hospital, it should be either my wife's or mine to balance the risk of death due to stroke and/or intracranial hemorrhage or hematoma with the ability, or lack thereof, of access to the appropriate diagnostic facilities for treatment. I have confirmed that each Sacramento Metro ambulance contains a (1) defibrillator and (2) the ability to administer a Diltiazem drip while in transit, the same treatment which would be administered upon arrival at the nearest medical facility.

It is both necessary and unfortunate that rules are established for macro purposes which exclude alteration for the informed micro (individual) need. I have taken the time to discuss this issue with a number of paramedics who have uniformly indicated that unless there is a specific exception provided to Document 5050.13 for them from your office or the Metropolitan Fire Department, they will not respond to my request for fear of an individual licensing sanction. It is to that end that I am writing this letter.

The inability for me to obtain an exception to the directions provided in Document 5050.13 to an onsite EMT when I am experiencing A-Fib and being transported to Mercy San Juan Hospital may prove to result in a far worse outcome than the transit time to UCDavis at a non-peak transportation period. No individual should be confronted with the choice of waiting for a taxi to arrive for transportation to UCDavis during a period of acute medical distress because of a "rule" which will not allow transportation by the Metropolitan Fire Department if it arrives first.

By this letter I request that you please provide me with whatever is necessary to provide to the Metropolitan Fire Department to allow transport to UCDavis Medical Centre regardless of the parameters set forth in Document 5050.13, i.e., and amendment as suggested in the attached addendum or a letter approved and signed by a representative of both the Metropolitan Fire Department and the Emergency Medical Agency that a paramedic will accept as authority for transportation to UCDavis Medical Centre. In making the decision to direct the EMS technicians to bypass Mercy San Juan Hospital, both my wife and I will balance the risk of death due to intracranial hemorrhage or hematoma with the ability, or lack thereof, of access to the appropriate diagnostic facilities for treatment.

Unfortunately, Doc. 5050.13 is so broadly designed that it does not allow for special needs of individual patients. More importantly, individual paramedics refuse to vary from the protocol, no matter the patients request for fear of losing their license.

In addition to presentation of this letter, I request sufficient time to (1)

Hernando Garzon, M.D  
5 August 2016  
Page 4

present arguments in support of this position and (2) for the individuals present to discuss the proposed amendment and ask any relevant questions.

Please confirm time and location of the next meeting. Thank you for considering this request.

Yours truly,

A handwritten signature in black ink, appearing to read "David Warren". The signature is written in a cursive style with a long horizontal flourish at the end.

David Warren

Cc: Rick Heyer, Sacramento County Counsel

PROPOSED AMENDMENT TO PROTOCOL 5050.13

Policy:

A. The patient meeting special triage criteria shall be transported to the designated Special Triage receiving facility approved by the LEMSA.

*B. Patients likely to require specialized services as identified in treatment protocol may be transported to the most appropriate receiving facility.*

*1. A patient presenting with the requirement of special medical needs for treatment, by way of example, but not limitation, implanted pacemaker, cochlear or other implanted prosthesis, shall be transported to the receiving facility which may provide appropriate treatment upon arrival even if it puts the patient at risk if the patient or the patient's authorized representative pursuant to Probate Code §4700-4701 directs transport to an alternative facility approved by LEMSA.*

*2. Prehospital care personnel may deny the direction if, in the opinion of the prehospital care personnel, exigent circumstances, by way of example, but not limitation, traffic conditions, patient's medical condition is too unstable for lengthy transportation, patient is non-responsive, exist.*

C. If there exists no medical condition that the prehospital personnel believes is unstable and no Special Triage Policy applies, then the patient shall be taken to the facility chosen based on the following (in rank order) decisive factors:

1. Patient's/Guardian's request (if patient is a minor)
2. Family/Guardian's request
3. Private Physician's request
4. EMS System Resource availability, as determined by SCEMSA in coordination with the EMS Chiefs.
5. Law Enforcement Request

D. Law Enforcement shall be responsible for patient in custody.

E. Direct medical oversight shall be utilized to aid in arriving at a destination decision in the following situations:

1. Patient's condition is believed to be unstable by the Prehospital personnel's assessment and the destination is not the most accessible facility.

2. Special Triage Policy dictates a different destination from the destination based on patients, family/guardian, private physician's, or law enforcement's request.

3. Control facility makes all destination decisions for a Mass Casualty Incident (MCI) or during a countywide level II, III or IV expanded emergency.

F. Direct medical oversight, when utilized, shall be the overriding decisive factor in determining destination.

G. Non-trauma patients under Cardiopulmonary Resuscitation (CPR) shall be taken to the most accessible receiving hospital.

H. Trauma patients with unstable or obstructed airways or tension pneumothorax(es), that cannot be stabilized, cleared or relieved in the field, shall be taken to the most accessible receiving hospital.

I. Any ambulance presenting at an emergency department carrying more than one patient will off-load all patients at that emergency department, except as directed by the control facility during a declared MCI or area wide emergency.

*J. The County of Sacramento, Emergency Medical Services Agency, upon presentation of and an application along with a processing fee to be paid by the applicant, including documents (1) holding the Emergency Medical Services Agency and the Fire Department harmless of and liability; (2) documents demonstrating a medical need to be transported to Special Triage receiving facility approved by the LEMSA which is not the closest facility and (3) documents sufficient to satisfy the Emergency Medical Services Agency Director that a patient or his designee pursuant to Probate Code §4700-4701, fully comprehend the life/safety risks associated with transportation in an emergent medical situation may provide a written authorization to the applicant which must be renewed five years from the issue date that a patient may be transported to a Special Triage receiving facility approved by the LEMSA which is not the closest facility at the patient's own risk.*