Sacramento County
Department of Health and Human Services - Emergency Medical Services Agency
Joint Medical Oversight (MOC)/Operational Oversight (OOC) Committees

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Sacramento, CA. 95827
November 9, 2017

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

Scribe: Kathy Ivy, EMS Specialist II

Meeting Attendees MOC:

- Nathan Beckerman, M.D. Mercy San Juan Medical Center
- Keven Mackey, M.D. Fire Departments
- Karen Scarpa, M.D. Sutter Medical Center, Sacramento
- David Shatz, M.D. UC Davis & Sacramento Metropolitan Fire
- SCEMSA Staff

Meeting Attendees OOC:

- Danny Birmingham, ProTransport Ambulance
- Kevin Otterstetter, Falck Ambulance
- Ken Bradford, Falck Ambulance
- John Brooks, NorCal Ambulance
- Larry Brown, Bay Medic Ambulance
- Matthew Burruel, AlphaOne Ambulance
- David Buettner, UC Davis
- Julie Carrington, Cosumnes Fire Department
- Scott Clark, Cosumnes Fire Department
- Johnathan Davis, Sacramento Metropolitan Fire Department
- Aaron Dean, Sacramento City Fire Department
- Theresa Franklin-Piercy, Mercy Folsom
- Wendin Gulbransen, Kaiser Hospital, South Sacramento

- Jared Gunter, American Medical Response
- Ryan Harrington, Sacramento Airport Fire
- Randall Hein, Sacramento Metropolitan Fire Department
- Sarah Kendall, REACH
- Mark Mendenhall, Medic Ambulance
- Hillary Mitchell, Kaiser Hospital, Sacramento
- Anthony Nguyen, NorCal Ambulance
- Joyce O'Connor, Mercy San Juan
- Kevin Otterstetter, Falck Ambulance
- Mark Piacentini, Folsom City Fire Department
- Jack Philp, Sacramento Airport Fire Department
- Sean Pfeifer, TLC EMS Ambulance
- Brett Shurr, Cosumnes Fire Department
- Kylee Soares, Sacramento Regional Fire/EMS Communication Center
- Michael Taylor, Sacramento City Fire Department
- SCEMSA Staff

- **Minutes Approved September 14, 2017:** - Dr. Garzon, SCEMSA Medical Director- Chairman - **APPROVED**

Topic	Minutes

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Welcome and Introductions	Chairman's Report: Quality Data reports. Dr. Garzon has a PowerPoint (available upon request). The TAG and Data group have been working on data but Dr. Garzon wanted to make a couple of points, due to it being a system wide issue and prehospital care documentation issue. This conversation is mainly about the prehospital documentation quality. Evidence based data helps drive an improved system but the quality of that data highly depends on comprehensive and standardized documentation practices for all prehospital providers. When looking at the information there are some gaps on what gets reported, some of it technical, what gets reported to ICEMA, but some of it is variations in documentation practices that give us less than useful data. When looking at the data bases with Image Trend that's reported to ICEMA, the differences are so wide we can't get reliable data on half of the Core Measures that are required. These are the most basic elements we are supposed to be tracking and looking at, and we're not even getting reliable data around that. The target is to at least get the core measure data. Taking into consideration provider documentation needs, this is not meant to increase paramedic work load with documentation, it's about accuracy and consistency, and lastly, we want to be able to fulfil the Sacramento County Agency targets we set for ourselves. There's a couple of areas and the first one we've already talked about; the data and TAG group have been working on defining some documentation list for QI elements that are meant to simplify and standardize our documentation. For example : the primary and secondary impression list that NEMSIS 3.4 uses are the ICD10 diagnostic codes that are really written for health care. Many of those have no place in prehospital health care because many of those ICD 10 codes require you have lab results back or radiological evaluations. So honing down the 100s of ICD 10 codes that are relevant for prehospital providers to create some consistency. Same thing with procedures, why should there be procedures that aren't in the scope of practice? It's just confuses things. For example there's a supraglottic airway BLS double lumen, there's also a supraglottic airway ALS King Tube and if you leave both of those there as selection options and there not in our scope of practice, it just increases the likelihood of getting bad data. Same thing for medication. So simplifying that and limiting what's available to checkoff for PCRs, I think improves consistency of documentation. Beyond those list is to define critical documentation elements that apply to the Core Measures. For example, if we're tracking glucose needs to be given for stroke, if you have a primary impression of stroke, it should become a requirement to check off the glucose. Sometimes, it's being documented in narrative, as a procedure or in vital signs and that inconsistency makes it very difficult to QI. Critical elements should not be in narrative because that then requires us to go back and look at every PCR to see if glucose was done. When looking at the core measure data alone it's not even clear with our current documentation practices if transport to trauma hospitals and trauma criteria is being met consistently by all providers.

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	Dr. Garzon specifically calls out the primary and secondary impression list and how the inconsistences of documentation make it hard to get the data. Some of the reasons this occurs is because some of the hospital diagnostic codes are not appropriate for prehospital care. Another problem is still getting from some providers, primary impression "not available" which is either a documentation issue or a mapping problem. Dr. Garzon ran data for third quarter of this year July, August and September of this year there were 455 different primary impressions that came up. What Dr. Garzon did was highlight the 66 that come from the EMSA list that we've adopted tentatively through the data group that we're still discussing, I've highlighted in red and the ones in yellow can easily be collapsed into the ones in red. For example, for chest pain, the primary impressions list has chest pain non-cardiac, chest pain suspected cardiac, cardiac dysrhythmias and there's variation because some are reporting chest pain non-specific , chronic chest pain and a bunch of others things that don't fit into useful QI categories for EMS. There are also dozens of trauma codes which increases the variation and do not help from the QI perspective. The list of 66 impressions by EMSA includes three (3) trauma codes, trauma injury, traumatic arrest and burns, that's it. From the QI perspective that simplifies it. Dr. Garzon pulled out the 66 measures from the 455 different primary impressions that came up and the ones not in red are actually three (3) of the items where no one used those as diagnosis over the entire quarter (stings, bites, pregnancy and complications). Dr. Garzon showed the total number of cases shown within the 66 diagnosis and didn't call out any particular provider but thought it was important to show where everyone stands. Percentages showed on what agencies that comes within that 66 diagnosis. There are multiple issues that we need to address to have accurate data. We need to focus on medics using these 66 diagnoses as primary/secondary impressions. David Magnino states the Not Available needs to be fixed, it shouldn't be happening. Dr. Garzon calls this an initiative because there are multiple issues that need to be addressed. The path forward for the agencies will be based on, is it a technical issue or is it too many primary impressions and why is that, maybe it's something to do with software etc. Question: How frequently would SCEMSA give the providers this information? It's good information to see if we can improve. Dr. Garzon said it's not hard, we can it for last month, quarter or wherever period of time, Dr. Garzon was thinking a monthly report, but certainly quarterly. David Magnino suggest we give the providers the rest of the month (year) to work on it and then SCEMSA will look at it again in January. Dr. Garzon was on the group of medical directors that came up with this list at the state level. There are a couple of things missing but it's really focused on prehospital care not hospital care. Dr. Garzon wants the data group to review this a bit more and refine/define it more but we need to be somewhere close to 66 and not 455. David Magnino states we are with NEMSIS 3.4 until at least 2020, they were able to push it back until at least that time and have more of an update in January meeting after the December meeting coming up.

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Public Comment	**None**
Supplemental Old / New Business	**Medication Shortages/Updates:** Dr. Garzon spoke about the national shortage on saline which is expected to worsen due to the facility in Puerto Rico is down due to the hurricanes. Epinephrine is on a short list, prefilled 1:10,000 back ordered 200 units. They are getting to point where we need to start mixing them. Dr. Garzon states you just need to be spot on with any dilution. San Diego has a really good protocol on how you check and confirm it. **Wall times:** David Magnino made a presentation to public health advisory board and one item Dorthy found in gathering the information and we only looked at the four (4) fire agencies 106 pts with no APOT data. They were either thirty (30) seconds or less, so just be aware there has to be some kind of number in that slot. Randy Hien spoke about data on wall times that they are seeing a positive trend and are equivalent to what we saw in 2015. David Magnino confirms that and you can see the decline in it. It may be too soon to determine if it's working but this is a good sign. Dr. Garzon states they are expecting a bad flu season. **EMResourse.** Ben Merin spoke and had EMResourse pulled up on screen for all to see: Ben Merin starts with a brief overview on what it looks like and where it's going. EMResourse is used by the MHOAC program which is an important tool in Sacramento and is more active than it ever has been. Currently the hospitals can see only their color score and see how busy they are. Able to track how many psych holds they have and how many boarded patients are there. We use it to track the NEDOCS score and the data can be used by county health to evaluate the effectiveness of their programs once we eliminate the psych holds from the data. Initially when the project was started the argument was that the ERs are so busy due to the number of psych holds they have, and yes it is a problem but the bigger problem turned out to be the boarded patients in the ED which flows into the hospital process, discharging, rooming etc. SCEMSA also have included the ambulance companies and Fire departments. This program has been in the county for almost 15 yrs. now but it's never been used until now. EMS has just recently been introduced to this. We can use this as a central communications, so if you need to know who to call at AlphaOne because you have a patient that was transported for infectious disease the hospitals can just click on AlphaOne and see who they need to contact. Same thing for EMS, they can click on the hospital and see who they need to contact for whatever information I need. Dr. Garzon asks if this is updated by the hospitals. Ben replies yes. Ben states hospitals are currently updating this 3 times a day. What Ben has recently added to EMResource is the 43 skilled nursing facilities in the county and developed mutual aid systems so if we have to evacuate an area we can now poll the skilled nursing homes and evacuate the skilled nursing patients there instead of the ER. The information isn't all up to date

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	yet, but for EMS and hospitals if you need to know who to contact for what you can look here, it's basically like an electronic rolodex for communications throughout the county. Ben also explains that EMResource is also what we use if we have a major incident, we can poll all the hospitals and know within 60 minutes how many beds are available in the hospital. EMS has recently been introduced to the bombardment of operational announcements. During the fires Ben was requesting strike teams over this, it's just a blast source for the entire medical and health community and medical emergency management can have one source of location. This is the one place we can get everything done, bed polls, announcements, etc. There is going to be a lot more EMS involvement, and I'll work with EMS. Chief Shurr has asked Ben for a written description, but Ben doesn't' t have one because it's been around for 10 years and he's just kind of making it up as he goes along, knowing it will be valuable so wanted to try it. One example of change is skill nursing specifically. He can now poll all skilled nursing facilities and within about 30 minutes know how many beds they have and can help decompress the hospitals in a major incident. The next plan for this, and we are about 90% sure SCEMSA have the funding for this, the CAD interface, which I'll be approaching dispatch with once we know we have secured the funding and then Ben showed on screen what it would look like and that it will help with APOT, Live monitoring of APOT. Right now SCEMSA does monthly reporting and you guys have to run the reports, but what this will do is, automatically every 30 seconds, it will update a number and what hospital they are in route to and when it gets to its designation and how many units are at that designation, it is not agency specific it is across the county, all ambulances in the county. As soon as the unit gets to the facility it will start counting and once it gets to 20 minutes, APOT calls will count and that number on right is longest unit time. So this is live CAD monitoring. The importance of this is, Ben's overall project with this is we're developing a county wide assessment of how busy we are, for hospitals, EMS, everybody so we know, one agency may be busy, others may not be and there's not a lot of information sharing at this point, so eventually everybody in the county, EMS, all hospitals we see all of the information. Currently the hospitals can only see their scores but eventually everybody will be able to see it, EMS, the hospitals will see each other's, the CAD data, everyone will be able to see everything, so that when there are decisions that need to be made about maybe going on internal disaster for overcrowding, Ben is not the only person that will be able to see the whole view, everybody can see the whole view and everyone can make an analysis of what is going on and if a hospital goes on internal disaster, it's not Ben getting a 1000 phone calls saying why are they so busy, everyone can look at this and say "oh yeah the counties busy we can see Sutter, UC Davis, Mercy General are all in black, there in the disaster mode, so this is why San Juan is picking up extra ambulance traffic. We all know right now how the crews will talk about the wall times here are super busy so there going to try and go to another hospital, it's happening, unofficially, but we all know it's happening, so this is going to go down the road and be a more official/efficient way to manage EMS system and manage wall times and that's the

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	purpose of this system, so the take-a-way from this it's going to be around more, I'll work with EMS to get you that vision of the future but in the meantime, everyone has access to this, every agency has somebody that has access to this and at the very least right now, make sure your information is up to date so we can use this as a county wide information/communication tool. Any questions? -Scott asked if the list is accurate and up to date because it looks dramatically different then what he has. Ben stated he doesn't have to keep a list any longer that EMResourse is up to date and can be used to obtain the information needed on supervisors, infection control contacts etc. -Randy, two fold, Nedox score updated three (3) times a day, what are the intervals? Ben states, right now it's every eight (8) hours, Dave and I are working with the hospitals at the executive level on a different project and that is likely going to be every two (2) hours and maybe as time goes on, every hour. The hospitals executives want it this way and they also asked why they couldn't see all the hospitals as they would like to see what's going on over the entire county as its important information and everyone should be sharing. -Dr. Mackey, two (2) things, I want to publically compliment you because this is huge. The amount of work you've put in and the value this brings to the table is gigantic. The second thing is I know we have the ability for the skilled nursing facilities, also huge, have you thought about getting the pysc facilities on this? Ben states he has and they are in EMResourse already, the challenge I have, and I have a bed poll so I can poll them now, but the challenge I have with them, just like skilled nursing facilities is the administration turnover is constant, so it's been a lot of work reengaging them but I am currently working with a core group of them now that has the contact with all those so we will start having more information on that and the list will expand. Currently is the licensed psych facilities but the plan is to add the other centers, so we are going to be expanding this program but for now Ben is working on finishing the skilled nursing side. David Magnino state the program is so expandable – Reno has been using the tracking for years now, they even have all their dialysis centers on EMResourse because it helps them on their disaster plan. One dialysis in Elk Grove already reached out wanting to know how to get on to EMResourse. SCEMSA has owned this whole program for years, but nobody ever used it to its capability. Ben Merin states the long term plan for this is if downtown Sacramento floods and UC Davis gets 30 dialysis patients saying, I just need dialysis, UC Davis can log in and say, that dialysis has availability you can go right there and manage all the medical needs in the county. The last thing Ben Merin wanted to show everyone is the hospitals have been involved for a long time, and EMS may or may not be aware about the patient tracking system. It's an electronic based tracking system, from his knowledge there are several counties/LEMSAs working on this, but I think we are the closest county getting ready to implement this system. There will be a lot of training and stuff coming out in the next six (6) months but this is designed specifically two (2) things:

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	1) Family unification during disasters. We can track patients, shelters, flu vaccination clinics, etc. but our focus initially will be MCIs and large scale disasters and family unification will eventually be at the county level were 211 will be primary source of contact for individuals to locate their family and 2) This helps hospitals meet the requirements for joint commission's rules with patient tracking. With EMS Ben has had several conversations over the last year or so and tested it with Sacramento City Fire several times. So this is also coming, piggyback off the situational awareness, then incident tracking, and tracking patients. We will get more into this down the road in other meetings. Dr. Garzon states this is critically looking at it from the disaster management standpoint. Ben Merin states, Sacramento City just had a meeting with all the city managers, chiefs, mayors etc. and said what we do if Vegas happen here, so now Sacramento City is looking at this now, law enforcement for psychiatric patients and OES. So there are many uses for this system. Dr. Garzon agrees that EMResourse as a software product/tool is wonderful and Ben has done incredible things with it, but what's more important to him is a the 50,000 foot view with oversight and coordinating and actually having the MHOAC and speaking from experience, not all MHOAC are the same. Dr. Garzon is very excited that Ben has taken this on because Sacramento County needs to be prepared. Thank you Ben. **Old Business: NONE** **New Business:** **PD# 2523-** EMS Radio Report Format- **APPROVED**- Effective immediately **PD# 8833**- Ventricular Assist Device (VAD)- Edits made- **APPROVED**-Effective immediately
Scheduled Program Documents for Review	**PD# 4510-** EMT Training Program- **APPROVED** **PD# 4511-** Advanced EMT Training Program - **APPROVED** **PD# 4520-** Paramedic Training Program- Edits made- **APPROVED** **PD# 8063-** Nausea/Vomiting- Edits made- **APPROVED** **–** *question about pregnant patients and Zofran. Agreed by physicians in group that to modify policy to withhold for first trimester (< 12 weeks) if not already using Ondansetron. CAB modified to ABCs.*

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	PD# 8066- Pain Management- Edits made- **TABLED** bring back in January. *Discussion about O2 sat being added but then agreed to remove due to respiratory depression with fentanyl. Respiratory changed to > 6 from >12, removed no evidence of torso injury on complete secondary exam.* **PD# 9013-** Pediatric Shock- Edits made- **APPROVED.** *Removed with saline lock from ALS treatment section. Add cross reference to pediatric parameters* **PD# 9014-** Pediatric Cardiac Dysrhythmias- Edits made-**TABLED** bring back in January. *Remove saline lock from Brady flow chart. Atropine max dose should be 0.5 not 1 mg. Added midazolam prior to TCP.Pacing removed 80-100 and added sync to age appropriate heart rate. With the Tachy algorhythm suggested to make closer to PALS. Dr. Garzon suggest taking this offline so we can compare PALS to ours and change because simpler is better.* **PD# 9017-** Pediatric Trauma- Edits made-**TABLED** bring back in January. *Doubled notes, remove. Saline lock removed out of Establish IV/IO. Question about ETT placement since pediatric intubation being removed soon.* **PD#9018**- Pediatric Pain Management- Edits made- **APPROVED.** *Edits made to reflect that of the adult pain management protocol. CAB changed to ABCs. Remove syncope and from pain management.*
New Topics	• 8827- 12-Lead ECG Dr. Mackey- Edits made-**TABLED** bring back in January. *This was brought back to clarify which ECGs should be transmitted. If the hospital ask for the transmission of a 12-lead then its fine to transmit but to do so just because, then it creates something the hospital needs to react to. It should not be every ECG transmitted. Discussion on whether it should be paramedic discretion and Dr. Mackey disagrees. He has tracked every transmission since 8/25/17 and 130 had been transmitted, 88 of them did not indicate STEMI. Dr. Mackey had read every single one of them and there was one that was transmitted that was actually a STEMI but there were 42 transmitted that read as STEMI of those 32 actually met criteria to be called a STEMI, 10 of them were false positives. 76% true positive rate which is exactly what the manufacture states it will be. The only time a paramedic should be transmitting a 12-lead is when it reads ***STEMI*** or when a paramedic doesn't know what the rhythm is and needs advise. Dr. Mackey states he will be taking care of the paramedic education and has already begun but there are some problems they've identified already, the Chest Pain policy actually states to transmit all computer interpretations. Dr. Mackey doesn't think the paramedics have been doing anything wrong; they've been doing exactly what we've told them to do. So we need to say great job, thank you and let's redefine things and let me do the education. Dr. Mackey has a PowerPoint that he is willing to share. Update chest pain policy 8030 with same language as in 8827 as an administrative change.*

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Roundtable	• Larry Brown is now with Bay Medic spoke about BLS transfers and if it's appropriate to send a patient BLS when it's trauma activation. Group discusses and states it's up to the sending physician to determine. Dr. Garzon states that the responsibility is on the sending physician and it's acceptable to have a BLS level response for trauma. Larry states he just wants to make sure they are doing the right thing for the patient. • David Magnino announced Pieter's departure with the agency; interviews for his replacement begin soon and hopefully start after first of the year. Also thanked all the providers that helped out with the EMS memorial bike ride back in September. It was great success. 2018 dates are already posted on http://www.muddyangels.com/. EMSAAC conference flyers are out. MHOAC -Dan Birch resigned his position and Rich Murdoc from Mountain Valley is the new person and we've already hinted that we need to start working on the new disaster medical plan. • David Buttener spoke about their EMS run review next week. • Karen Scarpa spoke about stroke and streamline patient care with EMS working with hospitals and if EMS could try and get contact numbers for patient's family, etc. because it's really important and last time normal instead of "10 minutes prior to arrival". Dr. Garzon states that is something the TAG working on. • Joyce O'Connor talk about SIPS program and EMS making the call to a phone number with the sheriff which will create a contact and after the 15th contact with ETOH patients (no other medical emergency) and on the 16th contact receive jail time for 120 days or detox program. The field has to activate it because they patient isn't under arrest so the hospitals cannot report it. The hospital can give the EMS personnel the paper with the number on it and can request the crew to make the call. You give DOB, brief description, medical complaint etc. • Wendin Gulbransen spoke about the "John or Jane Doe" names coming in and the complications it causes with the records/charts with the patients. Wendin also asked about the DART program and if the county still had a provider that does that and who is it. AlphaOne. • Mark Piacentini- Two weeks will have ten (10) new paramedics up and running and will be adding one ambulance to Folsom's fleet 24/7. August of 2018 5th fire station opening up off Empire Ranch Rd and will be station 39. • Randall Hein- Metro Fire is doing a program much like what Joyce O'Connor spoke about in the Carmichael area that began in April and they are collecting the data and will see how that program assist all of us with being able to minimize the impact of that specific group. • Julie Carrington- A document was sent out stating pediatric intubation was being phased out November 1, 2017, have we pushed that out? Dr. Garzon stated he will reach out to the state to extend our optional scope on pediatric

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	intubation until May 1, 2018. Julie asked who the Methodist contact was. Lori Bailey. • Brett Shurr announced they are in the process or recruiting 20 FF Paramedics to start academy in March. • Dr. Mackey spoke about scoring tools with dispatch regarding stroke. There's a dispatch diagnostic tool for stroke that scores from 3 down to 0. A score of 3 or higher means high likely of stroke. It basically follows the Cincinnati stroke scale. It's done with the caller on the phone. We are going to begin the training with dispatch to push that score out to the responding crews through the MDTs so they can see what the scores are wonders if we should train the dispatchers to get the contact numbers and last time seen normal. If crews don't give that information then the hospital staff can call dispatch and get the information. Dr. Garzon has some concerns it sounds like a different scoring system then what the field currently uses. Dr. Mackey states it will not conflict with county policies or a single thing the medics do, all it does is rise their level of awareness that this person after going through the screening with dispatch that this may be a stroke. Dr. Mackey will be doing the training with the field to let them know what it means. Dr. Garzon doesn't know if some of our medics even know what the stroke scale is or how to assess, document and make a disposition decision on current stroke patients. Dr. Garzon concern is just making sure the medics know what numbers mean and what scale to use and then use dispatch number only and not do a stroke scale of their own. Suggestion is not to report it to the medics just have dispatch have the numbers and state possible stroke. Dr. Mackey states this is just now being developed and not being implemented tomorrow. It's a conversation. Maybe leave number out and say probable, likely, highly likely. • Jack Philp- looking for guidance on training guidelines on EMT expanded scope. Dr. Garzon states we will not be providing that training it's in the scope. • Medic Ambulance asked about new hires. Example is they hired a very experienced medic that missed the orientation by one day and now they are sitting on a very experienced medic that can't work until he is county accredited. Wondering if there is a grace period so he's not sitting on him for 30 days. They can work with another medic for 30 days but they are 1:1 so that doesn't help them. Would SCEMSA consider a second orientation class? David Magnino states it's not feasible for us to run another class at this time and the medic cannot work on their own unless they are accredited, period.
Action Items	• Dorthy Rodriquez to pull data in January to see if numbers have narrowed. • Dr. Garzon to send out the list with medications, primary impressions/procedures. • Dr. Kevin Mackey to send 12-Lead ECG education packet to Kathy Ivy for dispersal.

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Adjournment	Meeting adjourned at 11:30

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

Next Meeting: January 11, 2018