Department of Health Services - Emergency Medical Services Agency
Joint Medical Advisory (MAC)/Operational Advisory (OAC) Committees

9616 Micron Ave. Suite 960
Sacramento, CA. 95827
March 8, 2018

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

Scribe: Stephen Harrington, EMS Specialist II

Meeting Attendees MAC:

- Nathan Beckerman, M.D. Mercy San Juan Medical Center
- John Rose, M.D. UC Davis Medical Center
- Greg Smith, M.D. Kaiser Hospital, South
- Karen Scarpa, M.D. Sutter Medical Center, Sacramento
- Kevin Mackey, M.D. Cosumnes/Folsom/ Sacramento City Fire Departments
- Jack Wood, D.O. American Medical Response
- Lee Welter, M.D. Sierra Sacramento Valley Medical Society
- SCEMSA Staff

Meeting Attendees OAC:

Sarah Kendall, REACH Air
Tracey Valentine, Sacramento Metropolitan Fire District
Brian Pedro, Sacramento City Fire Department
Mark Mendenhall, Medic Ambulance
Patricio Bedia, TLC Ambulance
Danny Birmingham, ProTransport Ambulance
John Brooks, NorCal Ambulance
Larry Brown, Bay Medic Ambulance

Anthony Bubba, Veteran's Hospital
Ken Bradford, Falck Ambulance
Matthew Burruel, AlphaOne Ambulance
David Buettner, UC Davis
Daniel Iniguez, American Medical Response
Aimee Burgess, Mercy San JuanMedical Center
Barbie Law, Sacramento Metropolitan Fire District
Mark Piacentini, Folsom City Fire Department
Theresa Franklin-Piercy, Mercy
Michael Taylor, Sacramento City Fire Department
Joe Thuesen, Sacramento Regional Fire/EMS Communication Center
Matthew Wion, ProTransport Ambulance
Brian Jensen, Hospital Council
Ben Merin, Sacramento County Public Health
Becky Rowe, Life-Assist
Heather Garcia, Kaiser
Jon Davis, Sacramento Metropolitan Fire District
Jack Philp, Sacramento Airport Fire Department
Derek Parker, Sacramento City Fire Department
Dennis Madding, Sacramento City Fire Department
Whitney Dufresne, UC Davis
Ken Boskovich, CHP
Brett Shurr, Cosumnes Fire Department
Anthony Ngymen, NORCAL Ambulance
Jared Gunter, American Medical Response
Ryan Harrington, Sacramento Airport Fire
Adam Watt, Sacramento City Fire Department
Taylor Stayton, UC Davis
Wendin Gulbransen, Kaiser Hospital-South
Hillary Mitchell, Kaiser Hospital-Morse Sacramento
SCEMSA Staff

- **Minutes Approved January 11, 2018:** - Dr. Garzon, SCEMSA Medical Director- Chairman - **APPROVED**

Topic	Minutes
Chairman's Report	Diversion Policy: guest speakers Ben Merin and Brian Jensen. Over a decade there was a Diversion policy being used in the county with over 8,000 hours of hospitals being closed due to diversion. Over a two year period a committee reviewed diversion closure minutes. During the two year review the committee was able to drop hospital closure minutes from 8,000 hours to 2,000 hours due to diversion. Motions for no diversion policy unless true hospital internal disaster was made, but not approved- Follow up needed. Hospital CEO's have been researching and developing a new policy that addresses certain high capacity conditions within hospitals. Hospital CEO's have already begun to approve this policy for use. Action: Will need to update EMS policies around hospital diversion if motion is approved. Brian Jensen was introduced to discuss a new Hospital Diversion "Decompression" policy. Currently, hospitals have diversion policies in place for internal disasters such as flood, fires, and active shooters. The goal is to use the "Decompression" Policy to address overcrowding in Emergency Departments. However, it was mentioned that hospital CEO's do not believe this policy will be frequently used. It was explained that hospitals want to use a quantitative matrix that requires there to be three conditions concurrently present prior to considering diversion. These conditions include the following: One, ED capacity is at greater than 175%, Two, must have a NEDOCS score of 220, three, the ED census must have 40%, or greater, of individuals on a medical or other type of hold. Only after these three conditions are concurrently present or met, the ED manager will contact the on-call hospital administrator to discuss diversion. If it is determined that hospital diversion is necessary, the Hospital Administrator will contact the County MHOAC to request a 120 minute (2 hour) diversion. After 2 hours, the hospital is expected to stop return to normal operations. If the hospital administrator, along with the hospital staff, determines that it is not possible to return to normal operations after the two hour diversion, they will contact the county MHOAC to declare an internal disaster. It was discussed that provisions would also be in place to limit a hospitals ability to stay in or initiate a diversion status. Those provisions include: One, no more than two (2) facilities in the county can be go on diversion at the same time, and, Two, only one hospital with a two mile radius can be on divert at the same time. Dave Magnino provides committee with the addendum proposed by the Hospital council, and advises that the MHOAC will be reviewing. In an effort to determine if the proposed policy could be effective, hospitals have been updating their ED census, NEDCOS score, and medical/psych holds data using EMResource to provide better situation awareness for all parties. This has allowed Dr. Garzon to review the census status for one week in January 2018 and all of February 2018. The data showed that if there are no changes to the current provision, one (1) hospital could have gone on diversion 27 out of 28 days, and the two mile radius would have been exceeded 16 out of 28 days. Dr. Garzon suggests that, if we are trying to avoid diversion, the current numbers would have to increase in a modified proposal.

Topic	Minutes
Chairman's Report cont.	Dr. Garzon continues to point out that using the amended provisions proposed by the Hospital Council, one hospital would have been able to go on diversion 23 out of 27 days, and the 2 mile radius would have been exceeded 8 out of 28 days. It was clarified that the decision to go on diversion is ultimately made by the hospital administrator who may use discretion to remain operating as normal even if the criteria has been met. The proposed policy will be a 12 month trial with the ability to adjust to the system's needs. The EMS agency will be closely monitoring, and will report any findings throughout the year. If the data shows adjustments or cancellation of the diversion policy is necessary to maintain a functional EMS system, the EMS Agency will make those changes. Dr. Mackey then asked for clarification in policy-region exclusive services, i.e. Pediatric trauma services, and further defines "Unstable Vital Signs" in diversion policy. Dr. Garzon stated we will go over the policy "from top to bottom" and refine and adjust as needed. A question was asked about what is shown on EMResource and Ben Merin stated that "Decompression is a hospital term, and not in the EMResource database." It was explained that on EMResource "decompression" will be shown as "Diversion." Dr. Beckerman then asked for more clarification and if this also counts for Trauma diversion as well, in regards to certification for Trauma centers and if Diversion policy will affect trauma patients. Dr. Beckermen stated the ACS monitors trauma centers for hours on diversion for certification. Dr. Garzon stated that a trauma hospital will not be on diversion for patients meeting trauma criteria if an ED is on diversion status. Ben stated that statistically in this county, diversion has never lasted longer than 20-30 minutes in the past. Dr. Wood had logistical questions in regards to how will the field crews know a hospital's diversion status, and felt it was a disservice to the community. It was once explained that this is starting as a pilot program, and dispatch can and will notify the field crews in regards to hospital status. Dr. Mackey then requested clarification about once a hospital comes off diversion, how long before they can go back on diversion, it was agreed upon that hospitals will have a cooling off period of 120 minutes (2) hours before they can go back on diversion. The group wants to add language addressing OB patients and their right to go to a hospital of their choice. It was argued that an OB patient would not impact the ED because they would be taken directly to Labor and delivery. The hospital council would like to have policy in place as soon as possible. SCEMSA will post policy as soon as revisions are made and then begin training. Goal is to have policy in effect by May 1st, 2018. Need to add language to address destination decision if patient's first choice is on diversion. Additionally, add language to define "Paramedic Judgement" when a paramedic may transport to a hospital on Diversion, and Dr. Garzon requested that the providers continue to educate their paramedics about the policy. Dave Magnino asked if everyone agreed with the policy becoming in effect May 1st, group agreed with edits.

Topic	Minutes
	New STEMI and Stroke plan requirements: Dr. Garzon informs the committee that the EMSA is changing regulations impacting the current STEMI and Stroke policies. These regulations will require LEMSA's to have a STEMI and STROKE plan. Dr. Garzon advises the group that we will need to form a STEMI and STROKE committee to include both hospital and pre-hospital representatives. The committee will review and share data of STEMI and Stoke patients. Paula Green has been hired by the SCEMSA to help write the STEMI/STROKE policies. Dave Magnino advised the committee that the regulations are due to EMSA by the end of the year, and we are trying to get the plans in place within six (6) months. These plans should not impact the current field policies, rather, it is intended to outline our process of defining and maintaining the STEMI and Stroke designated facilities in accordance to American Heart Association guidance. New HIPPA Regulations: Dorthy advised the group about dispatch HIPPA information. She stated that in HIPPA regulation, radio traffic is excluded in radio requirement. Therefore, phone call records need to be maintained for six (6) years and a log must be maintained to document when records were destroyed. This HIPPA requirement will take effect November 1, 2018. Dorthy provided HIPPA documents to the group. Dr. Garzon then brought up the quality documentation initiative, requirements for core measures. Dr. Garzon has been monitoring the initiative and recognizes that great progress has been made with potential for more improvements. Dorthy ran number's above 99%.
Supplemental Old/New Business	**Medication Shortages/Updates:** Starting August 2018 the Dopamine manufacturer announced that production will be delayed with no timeframe for when it will be available again for distribution. We will look into push dose vasopressor, i.e. Epinephrine, for replacing Dopamine. Dopamine was used three (3) times in 2017. Fentanyl and Morphine are also on delay at the manufacturing level as well. It is estimated that redistribution could take weeks. Epi 1:10,000 pre-load continues to have shortages, but distribution is expected to occur in the next week or two. SCEMSA will send out Epinephrine Dilution policy. Following patterns of most state LEMSA's and without FDA backing, Dr. Garzon does not want providers to use expired medication. Dr. Garzon stated with lifesaving medication such as Epinephrine and Dopamine, look at alternatives i.e. push dose Epinephrine and with Epi. Dilution policy, every instance used will be reported and reviewed by SCEMSA. Dopamine memorandum will be released notifying providers that the use of push dose Epinephrine temporarily approved if Dopamine availability

Topic	Minutes
	reaches critical low shortage levels. Providers will receive just in time training from their medical directors. Any usage of push dose epinephrine will require a report to be submitted to SCEMSA for review. The committee will continue discussions to eliminate Dopamine and move to using push dose Epinephrine. Initial discussion included to keep push dose Epinephrine in the same protocol as Dopamine, which requires Base Contact for administration. Dr. Mackey volunteered to put together training programs for Bolus dose Epinephrine. Committee will advise SCEMSA if there are any other medication shortages to be addressed in advance. SCEMSA will add a link to their website for providers to fill out in regards to medication shortages. **Old Business:** • **PD# 8015 –Trauma-** **APPROVED** **New Business:** • **PD# 2033 –Determination of Death-**Language Removed going into Cardiac Arrest Policy • **PD# 8031 - Cardiac Arrest-Language change**-Add Determination of Death Language. Debate with using mechanical compression devices and Dr. Mackey stated that with multiple studies, nothing has been proven that mechanical devices are better than well-coordinated personal compressions.- **Edits Needed** • **PD# 5060 -Hospital Diversion** – **Edits needed**-Once complete send to MAC/OAC members for approval.
Scheduled Program Documents for Review	• **PD# 2103-** Off Duty Provision of ALS by Sacramento County Accredited Paramedics – **APPROVED** with the minor edits • **PD# 5101- Interfacility Transfers-Medical Control- APPROVED**/with edits- Crew initially contact sending physician first with questions/orders. Crew tries to get name/number of sending physician. Change wording 'Agency' to 'Providers' • **PD# 5102- Interfacility Transfers: Level of Care- APPROVED** with edits • **PD# 5550- Bio-Medical Maintenance - APPROVED** • **PD# 8044- Selective Spinal Immobilization -** Providers review policy, make sure immobilizing proper patients, age/mechanism - **APPROVED** • **PD# 8802- Intraosseous Infusion – Suggested to Delete & language added under Vascular Access – APPROVED** to delete

Topic	Minutes
	• **PD# 8806- Intravenous Access (rename to Vascular Access)- APPROVED** with edits
Wall Times	Data separated by system wide, facility, 911 providers, and private providers. There were some facilities where the APOT times were longer for the private providers as opposed to 911 providers. SCEMSA is trying to pull data to determine why this could be the case. Most likely it is linked to patient acuity, however, SCEMSA wants to confirm by reviewing data from the entire system. By end of 2018-2019 EMSA will require all provider APOT times. Daniel Iniguez asked how AMR's data was being viewed because they have four (4) dedicated 911 units. Dorthy will attempt to separate the data between their IFT's and 911 units.
New Topics	• David Magnino, stated that Ben Merin no longer with the SCEMSA, but is still with the County. David Magnino announced taking resumes for interim coordinator to try and fill position quickly. Exam and list will be established in May to fill on permanent basis. • Dr. Rose is going to send out information to the providers and LEMSA for CPR at the capitol on June 7th, 2018. • Law Enforcement using Naloxone in the field and if follow up from the hospital is made, it's to give the officer that used it praise, and first use by SPD was two days after training took place.
Roundtable	• Daniel Iniguez stated that AMR is starting a 'Stop the Bleed' campaign and reached out to hospital personal about marketing/spreading word. • Kaiser North now offering free continuing education courses on a continuous basis.
Action Items	• Kathy Ivy will draft and send out Epinephrine dilution letter and epinephrine push policy in-lieu of Dopamine shortage • Diversion Policy will be sent out for review/edits for May 1, 2018 approval. • Dr. Mackey to put together a training PowerPoint for epinephrine dilution. • David Magnino to advise when a medication form is available on SCEMSA website.
Adjournment	Meeting adjourned at 11:45

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

Next Meeting: May 10, 2018