CASAC Meeting
Minutes – September 18th, 2024

Meeting called to order by Chairman Rosenberg

Approval of minutes – the minutes from the July meeting were sent out by SOCALR.
Are there any additions or corrections to the minutes? None
Motion to approve: Jill Dannenfelser, Seconded by Jonathon Siegel.
No objections to the motion – minutes approved.

State Medical Director's Report – Dr. Tim Chizmar

Protocol Review Committee – Dr. Chizmar

Video Laryngoscope – Dr. Chizmar

Please note we have been actively working on the next round of protocol changes for the next cycle. Questions have come up regarding Video Laryngoscopy. We are looking to add this into standard protocols. We are starting the process of looking at OSPs and determining if they need to be moved into standard protocols. Not every OSP will be moved into a standard protocol, but we are looking at OSPs. We also need to start removing protocols that we are not using and slimming down the protocols we have. Dr. Delbridge and Dr. Chizmar have discuss this area and talked about for every protocol we put in, we will endeavor to take one out. They are working to slim down the OSP section as it has grown very large.

As they look at Video Laryngoscopy, they have discovered there is a lot more literature available on it now than when they put it in the protocols seven years ago. It is time that they consider making it a standard intervention. Dr. Chizmar would like to have an ongoing conversation with the CASAC group with the deployment model with commercial services. It may not make sense to have a video laryngoscope on every single ALS unit out there. We need to have some deployment model where we can make that available to your clinicians. Dr. Chizmar had Scott Legore run a report on intubations that are done by ALS Commercial Services. There were a lot more than he anticipated. In the past year there were at least 5 pages on the report of intubations. Most of them were hospital based commercial services. He does think that we need to have a conversation about the deployment model with video laryngoscopes within commercial services. Dr. Chizmar suggested that we put this under old business and give everyone a chance to think about this change.

Education – Dr. Chizmar

As many of you are aware, we have had some proposed regulation changes around PMP renewal. Last year we took a pause. Received a lot of great feedback from both the commercial service educators and the 911 services. We are in a very preliminary phase of making another run at that. I just want to kind of bust this out there for any feedback that you may have. What we are currently iterating on is a didactic requirement of 15 hours. The three years of protocol updates which should be non-controversial. We talked about that before. Then up to nine hours of technical proficiency or skill proficiency, depending on how you like to term that. Up to nine hours dedicated towards skills proficiency evaluation. I know it came up in a prior meeting, and I took your feedback to our internal drafting process. The reason I said up to nine hours is because several of you said that you can accomplish that in a much more expeditious fashion than nine hours, maybe two or three hours. What we currently have in mind is that if you're able to do that and you want to do that in a short timeframe, for instance, if you were able to complete that within three hours, we would essentially have those remaining six hours become didactic hours so that we're not just having people stand around watching others perform skills or evaluate their technical proficiency. Dr. Chizmar paused for questions and there were none. He continued, I don't have anything in writing to share yet, but I just want to socialize this idea with everybody and acquire feedback. Any feedback or questions on that point? Scott Legore: Does everybody understand what he is talking about. Dr. Chizmar: So the EMT renewal, 24 hours, is not changing the total maximum number of hours. It would just be changing the division of how those 24 hours are divided up. Dr. Chizmar: All right, I'm hearing silence there, Will. Will Rosenberg: I guess everybody's okay with it. Dr. Chizmar: So again, our goals are to make sure that we introduce more timely didactic education into the EMT renewal process, both based on NCCP and based on QA/QI that we are seeing, and still allow enough time for the EMTs that need skills to be brought up to speed with technical proficiency or skills proficiency. So we will be socializing that information at a variety of upcoming meetings, and as soon as we have something in writing to share with you I will get it over to Scott Legore so it can be shared with you in writing.

911 Assistance – Dr. Chizmar

One other point, I know Scott Legore may hit it, but I just want to hit this briefly. I would just ask, kind of like we ask members of the public to reserve the 9-1-1 resources for existential circumstances. There have been a couple of situations recently that Scott and I have become aware of in which there are routine transports, planned transports back to the home or residence where the service gets to the residence and contacts 9-1-1 because they are not able to get the patient back in the residence. I know that there are extenuating circumstances, such as your ambulance breaks down, the patient has compensated, but I am just asking that for

transports that are predictable, if this is a larger patient, I leave it to you decide whether you're going to accept the transport or not accept the transport, but please try to send an appropriately configured crew. 9-1-1 may not always be able to back you up in a timely way. Scott, I don't know if you would like to elaborate on that any further. I know one or two services, not everybody, but we have seen a little pick upwards, so I thought it was worth mentioning here. Scott Legore: I can add on there that the biggest compliant came from Baltimore City. They received several calls all within a short period of time and they described the interactions with the commercial services as disrespectful. And they were even threatened with non-compliance to COMAR if they did not show up to assist, which Chief Matz took very offensively. In my last conversation with him, he has instructed his folks not to provide manpower assist to commercial services. I don't know where that's going to go. I think that is entirely within their realm, but it's unfortunate that it's gotten to that point. We did have a complaint from Howard County as well, and again, the commercial service was described as disrespectful. So, if you are going to request it, I would encourage your dispatch centers to tread lightly, because this is a hot-button topic within the 9-1-1 services. Dr. Chizmar: Thank you Scott. So again, I'm not going to get into the decorum piece of it. I would just ask that if you're planning to transport somebody who is larger to their home, there may be a need to have some other resource that you are sending with them. I'll leave it at that.

Clinician Services Announcement – Dr. Chizmar

I can share with you is that we have made an offer and an imminent announcement on a Director of Clinician Services will be coming very soon from them. And as soon as Dr. Delbridge and Randy are ready to share the name of that person, I'm sure they'll do so with Scott, and we'll get that out to you in writing. Scott Legore: So I spoke to Dr. Delbridge before I came down here. He has hired Aaron Edwards. He'll start October 2nd. He comes to us from Annapolis Fire Department where he was a captain. That's all the information I have.

Video Laryngoscopy – Will Rosenberg

One thing we glanced over, regarding the video laryngoscopy, is that I have told Dr. Chizmar that we are opposed to it in our organization. It's a small price tag, even a $3,000 device. That's $96,000 to us. So to my colleagues at LifeStar, AAA, and some of the other larger services out there, I'm not intentionally leaving anyone out of the conversation. You just need to understand that the fiscal impact of what MIEMSS is trying to propose. Dr. Chizmar" Will, obviously I know you and I have talked offline. I'm very sensitive to the fiscal impact as well and any protocol change that goes forward has to have a fiscal impact statement. I guess a couple of things I can say are that while the prices are not minimal, they have dropped over the past decade. The other real compelling thing is not to

just require another piece of equipment on there, but the data is actually very compelling, regardless of the device being used for paramedics who, let's be honest, paramedics, physicians, nurses, no matter who we are talking about, we're not getting as many people as we used to. We're not getting the muscle memory that we used to get. And we didn't require this because we frankly did not have data. Now there have been several large papers published on the video learning skills, again, not device specific. So I don't want to leave you with the impression that we're just trying to require things to require them. We're trying to make sure that if there is a tool that's been proven to be valuable to your paramedic that it's available to them. How we operationalize that through the inspection process, I'm willing to have conversation on, but I think it would be putting the ALF paramedics who does need to manage the airway. I know they don't have to do it as often in the commercial service world as they do in the 911 world. I do think that would be putting them at a disadvantage and setting them up for a failure. Which, again, I'm happy to have more conversation on it now or later if you please. Will Rosenberg: Mr. Larabee has a question that he put in the chat. It says in the 9-1-1 county systems, does every paramedic track have one or just the supervisors? Dr. Chizmar: Right now, Matt, it's an optional protocol. There are 18 or 19 counties out of the 24 big places that have that option. We would be requiring those remaining six to carry it on anything that they inspect ALS, Advanced Life Support. There is a fiscal impact. I won't beat around the bush with you. There's also a fiscal impact for cardiac monitors. There's also a fiscal impact for CPAP. You know, at some point, we have to move the system forward. We can phase that in or, you know, see how that operationalizes out. I certainly don't think it's useful for you to have it on every BLS transport unit where you're clearly not going to use it. I know some of you may use an ALS unit for a BLS transport, and if we could find a way to make this make sense for you, then I'm all yours. Will Rosenberg: Zach says, Pulse carries the cheapest disposable version for the SCT folks, single blade size. Is it a requirement that it be capable of video/photo? Dr. Chizmar: So currently with that, it does say that there has to be video capability, but I'll be honest with you, I am more than willing to work on that point if that's a hang up. Because I don't for the jurisdictions and the services that want to review it, I think it's very valuable. But if that presents a hang-up, I think it's probably better to have something, as opposed to not, foregoing it because of the video capability. Will Rosenberg: Zach says that those without recordings are significantly cheaper. Mr. Pixton, Mr. Baldwin, Mr. Buchholtz, or anyone else who has any thoughts? Jimmy Pixton: No, it sounds like he's made up his mind. Mark Buchholtz: If we can stay somewhere like the single patient disposable version that Zach is talking about, if we can somehow make those work to where it's a few hundred dollars, because in the inter-facility world the chances of intubation are slim unless you're doing standby services. I think there needs to be some give and take. Dr. Chizmar: Yes,

I'm more than willing to do give and take because I certainly understand it and I know there are some of you that have 9-1-1 contracts. By the way Mark, kudos to you guys. I witnessed the representation from the sidelines. I think ProCare was right there on the spot. Will Rosenberg: Teddy, any comments? Teddy Baldwin: No, I'm right there with you guys if we can find something cheaper we would certainly be willing, but at a higher price point in the neighborhood that you were talking about, three grand, it's a lot. We are already speaking a ton on stuff that we don't use, like charcoal. That's running astronomical numbers per case again. So, just more stuff that we don't use. Will Rosenberg: I'd be curious, Dr. Chizmar, were you able to pull the intubation stats, excluding MedStar, Hopkins, University, and Children's out, the dedicated critical care teams, and how many actual intubations there were in the commercial services? Again, I'll speak publicly for us. Short of an EMS standby, we had one last year. The only other ones were at actual standbys. Dr. Chizmar: Scott was able to pull some data. Unlike 911, I can't pull it directly myself from eMeds without a further understanding. I don't know if Scott has that data in front of him. Scott, I don't know if you can speak to that, not the individualized data, but the data that we collected on the group. Scott Legore: I don't have it with me. The number wasn't zero. I was actually surprised at how high it was. Dr. Chizmar: We will collect that. Again, this is September. Protocol committee meets again in November. You all have representation. I did and will continue to turn to them as well as I do for anything that has a fiscal impact. So, please make sure that they know what the feelings of CASAC are. Scott, if we can redouble and pull that data, give it to Will or give it to the group so it can be reviewed, not the individual cases, but the numbers so everyone can see what number of intubations. Will Rosenberg: As I knew my colleagues would be, they're very transparent. Pulse had one last year. ProCare had two. They were both at standbys. If you pull out MedStar, Hopkins, and Childrens, I bet you don't have ten combined. Dr. Chizmar: I believe there will be some Hart to Heart in there. But, they have a 9-1-1 contract. Some of you don't have 9-1-1 contracts and that's why I say it again, I think we can work with you but I don't think we should just across the board put your clinicians at a disadvantage. Jimmy Pixton: Well, I would like to say that if they're pulling the data from eMeds, we need to verify. I know all my wonderful medics are smart enough not to check a box, but they might have checked the intubation box when the patient is on a vent. We have had problems with medics clicking the wrong thing. Putting out the wrong statistics could be a possibility too. Dr. Chizmar: Lets put the numbers back out there. I think I'm not sold that video capability is an absolute to have. It's nice to have. So if that helps make this conversation even a little bit easier, I think this is go. This is good feedback overall. Will Rosenberg: Lifestar had one at a standby, so now we've just taken the five biggest services and we have a total of five. We will standby for Mr. Legore's data so we can dissect it. Again, we will revisit the data. Dr. Chizmar: We do need to move

forward and not put people at a disadvantage, whether it's one or a million people. We need to be aware of the price. Nobody's saying we should be buying $3,000 pieces for every single ALS ambulance we have. Will Rosenberg: But if I was to go back to Mr. Larrabee's comment, the point is that we have these requirements that some jurisdictions don't follow and you can't do anything about that, but you want to enforce it on commercial services. There are several drugs and skill sets, that I'll just use Baltimore County as an example, that may have another eight supervisor vehicles and there are some additional medics, around 40, that don't have them. Dr. Chizmar: I can totally understand that. I can tell you that Baltimore County with their new leadership has changed their approach. I know that they can't do it overnight, and I can't share what they're ordering, what they're not, but I can tell you that the position of Baltimore County has definitely changed. I know that it's been an issue for many years before I came to MIEMSS. Will Rosenberg: Anything else for Dr. Chizmar? Moving on.

SOCALR Report

Inspection/License Update – Marty Johnson

Inspections are going well. We are having some issues with several services being late with the submission of their annual renewal paperwork and scheduling their inspection. When you receive the renewal packet, at that point, please send out three dates that we can use to start scheduling your renewal. You don't have to send in the paperwork with those three dates. We need to start scheduling inspectors when we have those dates so we can all meet on one of those dates and everyone is happy. We haven't had as many issues with the renewal forms this year as we have had in the past. We are still trying to work towards getting this renewal process online as much as possible. We have no timeframe at this time as to when that online renewal process with occur. Scott Legore said he wanted to tag onto this subject. He mentioned late renewal paperwork and scheduling dates last year and it's occurring again this year. Here we are on September 18th and we have two September services that haven't even submitted their renewal paperwork yet or scheduled their inspection dates. Then on the flip side, we are currently receiving phone calls from services advising they are adding a unit and want an inspection the next day, but they haven't submitted any paperwork yet. There are some unrealistic expectations from the services that SOCALR drop everything on their schedule to come out the next day to inspect a unit. We have 35 services. There are times where we have three inspectors on the road doing three different inspections all at the same time trying to accommodate everything that is going on. I think some of the expectations are a little wrong. We are not looking to put any type of delay on these type of inspections, but on the flip side, to expect us to

drop everything to inspect your new unit the very next day when we haven't even received any paperwork is a little bit of a stretch.

Scott Legore also wanted to remind everyone that about half of the Medical Directors' physician's licenses expire at the end of September, this month. We ask that you look at your Medical Directors' license and try to be proactive. Start working on obtaining copies of their new licenses and sending them into our office. If not, you will be getting a reminder from Donna after the first of October to submit copies of the licenses.

QA Review/Data Import – Scott Barquin

One of the things we need to talk about is that we are going to be implementing a change in reference to the patient care report number that is going to be auto-generated by your services. We have noticed a little problem. It's come up that, specifically with TraumaSoft, that they issue the same run number to each and every service. So they start out with 1 or 001-24 and they keep going up for the rest of the year. He just picked a run number out of random, 1150-24, and he has 17 services in the State of Maryland who have the exact same run number in our system. So we have noticed that when the hospital runs a search under a run number, it comes up with all of these services. It doesn't specifically say what service transported the patient in. It just shows them 17 runs for that run number. So we are going to ask that the services, TraumaSoft, or whoever you use for your patient care reporting system, that you implement your service number in the run form. So, giving an example, I spoke with Leigha at MD ExpressCare yesterday, in some way, shape, or form, she would incorporate their license number 052 into her run form. I am currently looking at a report number 1150-24 that has reports from MD ExpressCare, All American, Butler, and ProCare. Everyone has the same run number. He talked with Teddy Baldwin and Teddy suggested that we add the service identifier at the end of the run form number. So in this example, the run form number would be 1150-24-052. The last 3 digits would be your service number. We are going to ask that this change go into effect January 1st. We are not going to do any changes to previous records, but we are going to try and get this under control going forward. MIEMSS and the eMeds community has also identified new numbers that are going to be added to some reports. They include account numbers, and that is a unique identifier assigned to the patient within the healthcare facility. So, if a patient goes to Shock Trauma, their patient care reporting system in the hospital can put a unique identifier in the patient care report as well, so they can keep track of that record. They can also be ambulance numbers, encounter visits, triage tag numbers, law enforcement numbers, secondary incident numbers, or any other numbers that they decide to put in there. This is another reason why we need to identify what service is doing this transport, identify who that run number belongs to. I can follow up with more information in the future. I have

spoken with TraumaSoft and they are aware of this change. They said they need to do some work on the back end to make this change happen. I have not talked to any of the other patient care reporting systems as of yet. I am available to talk or answer any questions you may have. Justin Kinsey, TraumaSoft, asked “Would it not be easier just to add the eResponse fields to the hospital dashboard so that they can see the agency name?” Scott advised that they are looking into the ePatients 01. The eResponse 03 is the run number. EResponse 01 is the same run number as eRecord 03. So, we have to distinguish the record number from the patient care report number. Justin Kinsey: Did you say that eResponse 01 is the same as eReponse 03, because that should not be the case. That’s not how the XML data is coming over to you all. EResponse 01 is the agency ID. Scott: I’m sorry. ERecord 01 is the patient care report number, eResponse 03 is the same number. Justin: Right. And so what I am asking, would it not be possible just to show eResponse 02, which is the agency name? Scott: We don’t put the eResponse 02 on the patient care report that goes to the hospital. So currently we have name, date of birth, age, status, service, arrival date, incident number, which is what we are talking about right now. Will Rosenberg: This is the first time I’ve heard of this and I haven’t talked to Justin, but I can tell you that we’d be vehemently against it. We use our run numbers across six services in seven states. We are not appending our run numbers to meet one XML. Justin Kinsey: To me, sending eResponse 02, which is in the XML data that we send to the state on every PCR, clearly identifies the service. I am confused why that wouldn’t work, because it does what you are asking and you are not asking the hospital to interpret either a prefix or suffix run number. They would have to look at the agency ID number and try to figure out which agency that is. They’d have to have a crosswalk to know which agency it is, whereas eResponse 02 gives the name. Scott Legore: We’ll take a look at that. The original request came from the hospitals with the conflicting incident numbers and I don’t know if adding that is going to satisfy their request. But we can look at it. Jimmy Pixton: How does the hospital get a run number? Scott Legore: Every time you transport. Jimmy Pixton: Patients to? Scott Barquin: The destination. Jimmy Pixton: 17 reports with the same run number is not going to be the same patient 17 times. You would think a hospital would know the patient’s name. Will Rosenberg: And statistically, those seventeen run numbers all went to the same hospital. It’s almost infinitesimally. Jimmy Pixton: Impossible. Will Rosenberg: I am highly opposed to it. Jimmy Pixton: We talking about billing status. You’re talking about a lot of people that search those run numbers. Now you are going to add more digits to those numbers. I’m totally against that. If you’re getting our agency name, all you have to do is turn it on for the hospitals. That’s a problem solved. I don’t know why adding our license number to the end of the number is going to help. They would need to know what that number means. I agree that it should say our agency

number. Mike Moretti: I think we are uniquely challenged at LifeStar and Keystone as well because we share the same CAD with unique run numbers generated and that would probably be virtually impossible to figure out on our side. Jimmy Pixton: In multi-state companies, that is not going to work. Will Rosenberg: That's my point. Scott Legore: We'll take a look at it internally. Will Rosenberg: So the follow up on some more hospital requests. Scott Legore: Destination codes continues to be a problem. Again we are asking that on the service side, you ensure that the right hospital code is put in. Scott Barquin does a good job of making sure you have destination codes, but we can't verify whether they are correct or not. We have hospitals making multiple requests through SOCALR for reports. And we have heard a couple of the hospitals saying that they have gotten less than a stellar response from the services when they make direct contacts. In fact, they've had a couple of services that flat out refuse to provide the patient care reports for patients transported to the hospital. So SOCALR shouldn't be the middle person. This is between you and the hospital. If we can improve on the destination codes, then if the hospitals do reach out to you, please provide the patient care reports. They are required to have it as part of the patient care record. Scott Barquin: Thanks for reminding me. We did have one hospital specifically request that your crews, if they go to University of Maryland, that they choose either University of Maryland ER or Shock Trauma. The hospital dashboard is different for that facility. So if a patient goes to trauma, but their report is in the University of Maryland, they don't have access to that report. They are asking that the crew specifically chooses where they are going to arrive. Will Rosenberg: The only problem with that is that often the crews don't choose the facility. It is chosen by the dispatch center. And as you may know, University and their 13 hospitals employs a central system called Ride Central. And as Leigha will tell you, they are picking the wrong facility. So perhaps looking in the mirror will be the first place to solve this problem. That's uploaded initially by Ride Central. So all the transports they order are from their hospitals. They are the ones choosing the destination. Scott Legore: I wasn't aware of that. Scott Barquin: Thank you.

Equipment Update - Scott Legore

No changes to the equipment list. I do want to say we are seeing more and more services add the powered stretchers and powered stair chairs. They are adding battery chargers to the units. The only thing we ask, and it's required by the regulations, is that these chargers are secured in the unit. If not behind a locking cabinet, they have to be secured on the shelf. If they are in an open space they can become a projectile during a crash. So, if you are adding these, just have been placed within a cabinet or properly secured.

Clinician Services – Randy Linthicum (Not available) – No report.

Committee Reports

PEMAC Report – Jill Dannenfelser – No report.

Scott Legore had a couple of items to add. There is a PEPP Course that he sent the flyer out this morning. It's a hybrid class with didactic done on line at home and the in-person day focused on pediatric skills, scenarios and simulation. The in person date is October 18th in Hagerstown. Please share this course information with your folks. And then the EMSC group came up with a new poster focused on Booster Seats correct use. They have single page flyers and a poster in reference to child safety seat boosters. It's English on one side, Spanish on the other side. It you are interested in these for your events or your facility, let Cyndy and Susanne at EMSC (cps@miemss.org) or I know and we can provide them to you.

SEMSAC Report – Danny Platt – No report.

MIH Report – Deb Ailiff (Not available) Mark Buchholtz – No report.

Old Business

Photo Collage – Scott Legore

SOCALR has sent out information about a photo collage several times now. We are working on a collage of all the commercial services. Sarah Pysell has done an outstanding job. She has sent Scott some drafts with the photos we have received. Probably less than half of the services have submitted photos of their units. So if you have not submitted any photo yet, or if you have a new photo, please send them into our office. We will be sending out emails, either from Sarah or Donna, asking for photos so we can finish up this project up.

MIEMSS App – Scott Legore

Scott Legore said he has been asked by Media Services to follow up on the MIEMSS App. The MIEMSS Protocol App has been out since July. We are looking at what the next steps are to be with that app. Todd Abramovitz' group is working on that. So if you have any thoughts or suggestions from your service or employees, please forward those to us so that they can incorporate them to make the app more user-friendly.

NEMT – Scott Legore

Scott Legore advised that he sent out the NEMT update from MDH. It went out this morning. It's a two-page long email. I am going to read a few lines from this. "So the statewide rate is anticipated to be implemented in physical year 2027." And then further down they talk about the unified statewide administrator will be responsible for screening, scheduling, and

oversight of the participant experience. This approach will replace the current process run by each local jurisdiction. I think you are all aware of that information. And they anticipate the completion and release of the request for proposal by October 28th, 2024. They have a website or email address if you have additional questions. It's at the very bottom of the page. So if anybody did not get this, feel free to let me know and I will send you another copy of it. I wanted everyone to know about it. I got this third hand. I'm apparently out of the loop on this. So you may have more information on this than I have, but I wanted to share what we received.

Non-EMS Driver Regulations – Scott Legore

Earlier today I sent out an email regarding the regulation changes for the Non-EMS Drivers. We had pulled that back because we found a typo. We also found a section that didn't actually match what we're doing. We pulled it back and I sent out the revisions. So we revised it. Most of what you are seeing here in the red line has to do with allowing the non-EMS driver to drive the ALS units and above. The three changes that we made with this last section in 30.09.94.08 A is that we took out the references to the individual sections to allow the equipment requirement waiver to apply to the entire section of COMAR 30.09. Section 30.09.04.08 B (3), we added the words "or maintaining", which means you have to submit the names of the folks and all the other monthly requirements, not only in the initial phase, but as your waiver continues. That is what we are currently doing. Then the typo was in 30.09.04.08 B (3) (f) where we spelled SOCALR incorrectly. Those were the three changes that we made. We want to get comments about it. If everybody supports it, we will take it back to the EMS Board and move it forward through the process again. Jimmy Pixton: I had a question because it seemed fuzzy to me where it states ensuring that an ALS licensed ground ambulance that is staffed with a non EMS driver is also staffed with at least two individuals who meet the following requirements. I disagree with this because I think this can be misleading to where the Nurse-Nurse Waiver could use a non EMS Driver. I think that it should clearly state a licensed EMS provider or certified EMS provider in Maryland. Claire Pierson: I was reading it and I guess that is a good point. I'll have to take a look at maybe where we can add some additional piece of language to ensure that an EMT or higher in on the transport. Will Rosenberg: Isn't a nurse higher than an EMT? Jimmy Pixton: Another higher? See, that's what I mean. It's not spelled out. Claire Pierson: So maybe we need to add language there to something along the lines of an EMS clinician? Jimmy Pixton: Yes, something along those lines. Claire Pierson: Okay. Scott Legore: But my understanding was that we were going to allow the non EMS driver to drive SCT units because there was a team in the back and they weren't part of the clinician team. Are we moving away from that? Claire Pierson: I know that was the request made with the idea that there was a sufficient team in the back, then there wouldn't be a need to have the EMS driver.

But I guess that's up to the group to determine what you think is appropriate. Will Rosenberg: I think Jimmy was, and Jimmy can speak for himself, concerned about the Nurse-Nurse, not Nurse-Paramedic, or maybe I am misunderstanding what he was concerned about. Jimmy Pixton: To the RN waiver, you could have a unit that has two nurses on board and a non EMS driver, and you would have no EMS on at all. I think this needs to be clarified. Claire Pierson: So I just want to make sure I'm understanding what you are saying, Jimmy, so that I can make sure that we're writing it appropriately. Would it be appropriate? Scott, we can talk. I mean, if folks have ideas about this, would it be appropriate to write that a non EMS driver waiver can't overlap with a Nurse-Nurse waiver? Is that the issue? Is that what you'd be okay with? Everyone, correct me if I am wrong. It sounds like everybody would be okay with the non EMS driver waiver being applied to an SCT unit as long as the Nurse-Nurse waiver isn't applied to the same unit. Is that right? Because there are two different waivers? We could either write into the regulations that you can't hold both waivers, if that's what you want. Or, we can just ensure that both waivers aren't applied at to the same units or service. I am not sure which would be easier, Scott. And does that solve what you are asking, Jimmy? You just don't want the Nurse-Nurse waiver and the non EMS driver waiver applied to the same unit, applied layered on top of each other, right? Jimmy Pixton: Correct. Scott Legore: It almost sounds like it would be cleaner to put that language in the Nurse-Nurse waiver than the non EMS driver waiver for those type of transports as opposed to trying to add language that would exclude a waiver that excludes another waiver. If that makes sense. Would that service the same purpose, Jimmy? Jimmy Pixton: Dr. Chizmar is sitting right behind you. Does he want a non EMS driver and two nurses running ALS and critical care calls? Or would he like an EMS provider on there? Because, if that is the case, then why do we need a third provider anyway. Dr. Tim Chizmar: I was trying to let everybody comment first before I jumped in. I think the whole premise behind having an EMS clinician, at least one EMS clinician per unit, is a couple of items. One is the unit familiarization. Because with the Nurse-Nurse waiver there is no guarantee that the nurse is employed by the service. It could be that they very infrequently ride the ambulance. Scott Legore: The Nurse-Nurse has to complete the training program that we have approved. Dr. Chizmar: They complete the training program, but there's also issues with how frequently they are riding the unit. Also, the primary issue is that a lot of the healthcare personnel can do a lot of things inside the hospital, but when you put them in a mobile unit they may need assistance going down the road. I agree with what's been said, I wouldn't apply the nurse-nurse waiver and the non EMS driver waiver at the same time. Jonathan Siegel: I, as somebody who utilizes a nurse-nurse waiver actually quite a bit, don't really have an issue. We don't have an issue not crossing over between those two waivers. But I would push back a little bit on your training familiarity comment. We are not using non-employees,

like we just have more nurses than we have paramedics, right? So it's all of our staff, it's just two nurses together. So they're familiar with the vehicles. They work in the vehicles. They're trained. Dr. Chizmar: Is it always 100% of the time? Or are their special circumstances where we take the hospital nurse with us? Scott Legore: But that wouldn't be nurse-nurse. That would be supplementing the SCT crew. Dr. Chizmar: I am fine with that. At any rate, I think we should not have both waivers overlapping. Clair Pierson: I think that I get what everyone is saying and from a policy perspective, it should like the group agrees that no one should be overlapping the nurse-nurse waiver and the non EMS driver waiver. Scott and I can take a look at that and figure out whether there is an appropriate way to put it in the waiver regulation. And, if folks feel strong that it really should be in the regulation, that those two cannot overlap, maybe we can add an additional section to the end of the regulation that say, no waiver that grants the following can overlap with a waiver that grants the following. That seems like it would be the easiest place to put it. Or we can just, by policy, can ensure that every time that a nurse-nurse waiver is issued, that we write into it that the nurse-nurse waiver can't be used on any unit that it's also using a non EMS driver waiver. I think we can accomplish it either way, but if folks have preference as to whether it's written into regulation versus executed as a matter of policy, then let us know. Will Rosenberg: I have a question but it has nothing to do with who's in the back of the ambulance so we're good. I don't know if we're done with that conversation, but I have a question about F9. It's the last thing on the entire page and very lawyer-ish "at their sole discretion". Wait a second here folks, like we've decided MIEMSS Executive leadership has decided the PSC is in charge of deciding who's qualified to be on an ambulance. But now it's so-called SOCALR discretion, not even Lisa Chevron's department. But any nurse can get in the back of the ambulance even if they have five murderous convictions because the Board of Nursing is pretty much useless. We're stepping all over ourselves here. Dr. Chizmar: I think the history on it was that we had compliance cases or integrity cases concerning different EMS clinicians. And basically, we were, in essence, they were saying that's fine. You can't be an EMS clinician. We'll just employ you as a non EMS driver. And some of the cases, they weren't patient care issues. There were conduct issues that even in a driving capacity would have an impact on the safety of the patient going down the road. It doesn't really help mitigate the safety concern. And that's where that was really born out of. Now, the language I will have to defer to Claire why it's written in exactly that way. I don't know. But it is in the spirit of what we were trying to get out there. I don't want unsafe people driving any ambulance that are unsafe. Will Rosenberg: No one on this phone call wants that. But I failed to understand why now MIEMSS is going to impose their will on non EMS drivers, but not on nurses. Like it okay to be bad in the back of the ambulance, but it's not okay to be a bad person and drive the ambulance.

Even it if were, we are going to say MIEMSS has this authority? Why is it not with a chief compliance officer? Why would it rely in SOCALR? Dr. Chizmar: I won't speak for Scott, but what I will say is the non EMS driver is a waiver. It's not part of the standard regulations. SOCALR has got responsibility for managing the waiver in the terms of the waiver. I mean that we set it up. It was set up as a waiver and wasn't written into the regulations that you can always have non EMS drivers. As far as the nursing board goes, it's specifically written to the law and that there are very limited things that we can do with nurses. The same could be said for firefighters because there's an overlap where they get on ambulances to help out and so forth. But I don't know. Claire, you can correct me where I've strayed there. Scott Legore: I think I can answer the question. That language came from Lisa's shop. It came from the Office of Integrity. But her office doesn't have a regulatory authority over non EMS clinicians. They only have regulatory authority over EMS clinicians. So if John Smith, who's a non EMS driver, has an issue or has some type of issue that raises a red flag in her office, she cannot take action against him or her. It would be fall on SOCALR. Which that is the reason for this. We do not plan to blacklist anybody unless we feel they are a danger to the health and we would definitely have a conversation with the commercial services before we do that. This came out of what we thought were some loopholes that allowed folks to slip through the cracks when there was a compliance issue and they could then drive as a non EMS driver. That would no longer fall under her discretion or her regulatory authority and would fall under SOCALR. Will Rosenberg: Well then, I go back to my original question, why are we not expanding this to nurses? When they are in the ambulances they fall under the offices of MIEMSS. Claire Pierson: I guess I'd say, because under statute and regulation, the nurses and the regulation of nurses is done by the Nursing Board. I don't even know that MIEMSS has the statutory authority to set up an additional secondary licensure requirement for nurses. The idea is that the nursing board should be handling regulation of nurses and if an individual is licensed as a nurse, then presumably they're not a danger to patient safety. And that is within the purview of the nursing board. EMTs and paramedics are within the purview of the EMS board. The concern was that with regards to the non EMS drivers. I get that they're within the purview of PSC, but there may be additional issues that we're aware of that would make them not appropriate for a waiver. Will Rosenberg: Listen to what you just said. Drivers under the purview of the PSC. Nurses are under the purview of the nursing board. But if we find the drivers are naughty, we still want the ability to kick them out. But if we find out the nurse is naughty, that's none of the auspices of the board of nursing. We are in plenty of double standards here. Claire Pierson: Well, it's not, because drivers licensed under the PSC are not specific to the healthcare setting, right? And, so I suppose, at some stage MIEMSS could have additional authority to set up an entire ambulance driver licensing system.

It does not, at this stage, have the statutory authority to do that. And it does not, at this stage, have the administrative ability to do that. But there is such a system for nurses, right? Presumably a nurse that is a danger to patient safety should have their license revoked or limited in some way by the nursing board. This is a waiver, right? Do we make a nurse-nurse waiver set up so you can't use certain nurses on ambulances if MIEMSS deems them to be a safety risk? I don't see how that works. The better situation is if there's concern with nurses in the back of ambulances is to have them reported to the nursing board which MIEMSS is required to do by law. So there is a legal setup for MIEMSS that is having a concern with a nurse, which is the requirement that any compliance issue that comes to MIEMSS regarding a nurse gets referred to the nursing board. That's in regulation already. So I think the idea is that by law, we are relying on the nursing board to do their piece. Will Rosenberg: But I would argue that you're relying by law that PSC do their piece. When an EMT does something wrong, they go to Lisa, they go to PCR, they go to the EMS board, but they can also file for an administrative hearing. They can drag it on for a two or three years before you revoke their license. What you are saying right here is at the "sole discretion" Scott Legore can say someone can't drive. That is a dangerous line in the sand to cross. Even if the PSC suspends your driver's license, you can go to an administrative hearing. But right here, Scott Legore, or his successors, can put their foot down and say "I don't like so-and-so, and at my sole discretion, the regs give me the ability to stop them from driving". Claire Pierson: I totally get you. Will Rosenberg: We're having four different channels that are not equal. Claire Pierson: So the option then, at this stage, is that we pull back this regulation and we keep it. We're not going to do the ALS waiver for a while. While we set up the ALS or SCT waiver, we can work on setting up some sort of appeal situation for individuals that aren't allowed to drive and that have been subject to compliance issues. I guess either by MIEMSS or otherwise. So there are a couple of options. One would be to expanding it to say the following individuals can't drive, people that have been through Lisa's process or whatever it may be. But frankly, if the concern is with Scott's sole discretion, then I think the appropriate thing to do is to set up an appeals process. That'll take time and money to develop and put forth in regulation. And we certainly can do that. So we can take this back and work on that and bring it back to you guys later with some sort of appeal process with regards to individuals that can't drive. I guess we'd have to see what that would look like, right? Fundamentally, you're not entitled by law to the waiver. So, the thought was that MIEMSS has some discretion to grant or deny a waiver based on public safety. And if a particular driver is a public safety issue, then you're not entitled to the waiver. If your concern is that an individual driver versus a service might have some issue with not being able to drive, then that's sort of a different regulatory setup and a different way we'll have to do it. Jimmy Pixton: Obviously this has happened, where somebody was revoked or

suspended as an EMS provider and they've come back around as a non EMS driver. Scott Legore: It never happened but when they were handed their compliance paperwork they said "I'll just become a non EMS driver and continue working." This raised a bit of red flags with Lisa's shop. Claire Pierson: Well, it wasn't just compliance paperwork. It was a summary suspension, which you all may or may not know, is rare and is also predicated upon a threat to health and safety of patients. But there have been additional issues in which there has been a driver that's engaged in concerning violent conduct in the ambulance. And what we realized is we don't regulate them in a way that we would be able to prohibit that person. Of course, you get fired by a service because you've stolen or hit somebody in the ambulance. You're the driver. So now they move to a different service as a drive. We don't have a compliance process for driver like we do for clinicians. We find out about it and there's nothing that we can do to stop that driver from just going to another service. So the idea behind this is that if it happens Scott can say that appears to be a health and safety or safety risk due to using the driver. We're not going to continue to approve your waiver if you're going to use that driver. I understand Will's point, which is, suppose that the driver disagrees. He did not punch that EMT that was sitting next to him in the ambulance. And that the driver ought to be able to challenge that, or that the service ought to be able to challenge that. I understand Will's point. Because we are in a waiver, we're not in a robust regulatory framework that would usually include an appeal of that sort. I think the other option is to build out more robust regulatory framework to allow that. It will take time and thought to do that. Teddy Baldwin: Could we not use the ePins? So is there nothing in there when they apply for an ePin that says this driver has been fired for punching someone and MIEMSS thinks there is a threat. Shouldn't they not be able to be affiliated with another service? Will Rosenbeg: We looked at that, didn't we Claire? Clair Pierson: We did look at that and Scott, you will have to remind me why we can't do that. Will Rosenberg: Because you can't restrict someone from apply for an ePin. It's not a certification. It's just a number they request so they can be documented on a report if not certified. Scott Legore: So let me throw this out and it may be jumping ahead, but so internally we've started the process to look at all of the 30.09 and updating them, dusting them off, and cleaning them up, because some of them are outdated. What are the thoughts of moving forward with this change because I know a lot of folks what this to move forward with the ALS to allow for the ALS units and then as part of the 30.09 regulatory change we look to make the driver waiver move out of the waiver program and make it permanent. I don't see us going backwards and if we do this, then we could build in an appeals process, similar to the disciplinary process that is currently built for all of the EMS clinicians. Am I stating something that is not true? Claire Pierson: No, I don't think so. I think that would be a useful thing to do. I would want to double check and make sure that we can create that sort of licensing

system that isn't in statute, but I can double check and see if there's a way that we can figure that out. Scott Legore: Even if we did not create the licensing on our own, which we thought was going beyond our statutory authority… if we were to take the same non EMS driver program, make it section 15 of 30.09 that would define who the driver can be as opposed to that and put them under the same disciplinary process that would then take the sole discretion from SOCALR, taking all the weight off of me. Put it in the regulatory statute and then we wouldn't have folks asking for yearly renewals for their waiver. This program, the way it initially started, versus the way we are using it now, has really changed a bit and we could streamline it. Claire Pierson: I think that would be particularly useful. The idea would be that there would be some sort of opportunity for a hearing or an appeal if a service contested our thoughts about a particular driver. We could add that in. Will Rosenberg: Just so everybody understands why I was hot on this topic. We had an EVO we fired, not for punching someone. I don't even remember what they did. We turned in a 5/25 to Lisa and she said, "That's great, but I can't do anything with it but file it in the circular bin." It just amazes me that even when you want to report an EVO, and now all of a sudden MIEMSS wants the ability to, we are kind of handcuffed by what we can and cannot do. Scott Legore: I think that was the purpose behind this, giving us some authority to do this. There's 180 of these folks driving around right now. The turnover is often and we want to ensure that the folks are safe out there. Clair Pierson: I think this language is exactly the stopgap that Lisa requested so that she doesn't have to throw things out and there's some kind of stopgap mechanism to do something when you turn in information. That was Lisa's red flag. So the addition of the language was an attempt to at least make a stopgap. The idea is that once this regulatory change makes its way through the process and becomes a regulation, then she wouldn't have to do that. Jimmy Pixton: You all are acting like PSC doesn't do anything. Has anybody thought to turn them into the PSC? Because if I have a driver that does something bad I can call the PSC and have their license removed. Their license is assigned to your company. It's not a license that jumps all over the place. So if you have a problem with a non EMS driver, then you report them to the Public Service Commission. The Public Service Commission is stricter than MIEMSS. When it comes to crimes, DUIs, drug possessions, and all, you could get a case a lot easier. So you should be reporting these people to the PSC and removing yourself as the sponsor of their PSC license. Will Rosenberg: Jimmy, we did and they no longer have one. But if they apply to AAA and you didn't pick up the phone and check on their reference check their conduct was unprofessional, it wasn't criminal, so they could get another PSC license. Jimmy Pixton: PSC is going to flag him and send us a letter saying this individual lost their PSC license because of that incident. Claire Pierson: I think that's a really good point and particularly useful. I think that it might still leave a little bit of a crack that folks could fall through, which would be

the clinician that MIEMSS merely suspends or revokes that then goes to get a PSC license. I guess I'm not sure at what stage in that process MIEMSS would report to the PSC. Jimmy Pixton: There's always going to be cracks. So let's say I am a paramedic. I killed somebody last week. I go back to college and get my nursing degree and turn up at John Hopkins in six months. What control do you have over the nurse? Claire Pierson: Well, I guess what I would say is in that circumstance, if you were a paramedic and you killed somebody last week and MIEMSS took action to revoke your license, we'd report that individual at the end of when there is a final decision. We'd report that individual to the National Provider Data Bank and the nursing board would then pull that information prior to attempting to license the person and realize that they had been revoked by MIEMSS for whatever they prohibited. Jimmy Pixton: I didn't mean kill a person on purpose. Claire Pierson: Even if it's somebody that steals from a patient or hit… Jimmy Pixton: Not doing CPR correctly, that's not going to… Claire Pierson: Ban them from … Jimmy Pixton: being there. Claire Pierson: We can't stop that unless they have done a standard of care violation that we take action on. This was really just an attempt to create some kind of bottom-level safety net where we could, as with the clinician, suspend the driver. And that was sort of the request, that the tradeoff is if we're going to expand this waiver, then can we at the same time build whatever safety net we can. I don't know what we can fix the whole system nor that we were trying to, we were just trying to make a stopgap where we could. I hear you, Jimmy. I understand that there could be other workarounds, loopholes, and cracks,that we should work to fill. This was an attempt to just do what we could while we had this open. Will Rosenberg: Any other comments, hands, thoughts, or opinions? So I guess that we need to decide is do you want us to proceed forward with this as is or pull it back and not take it to the EMS board next month and revise that section now. Scott Legore: There's several things tied into this so if we pull it back for that one section, it's going to delay all of them. That's entirely up to you guys. Will Rosenberg: There's two issues. At least the issue I brought it may or may not be an issue to some people, but then also have the nurse-nurse verson non driver. Those are tied in. Is that accurate, Claire? Claire Pierson: It's accurate. If the group feels that prohibition on the double waiver needs to be in the reg. We could achieve the prohibition on the double waiver by SOCALR refusing to issue both waivers at the same time. But that would be on SOCALR as opposed to in regulations. So you all would be relying on SOCALR not to issue both waivers. If you want it in regulation, then yes, that would be two things for which we'd be pulling back. Will Rosenberg: Alright, we're just going to do a little poll of the group here. So if you want to go forward, figure out how to raise your hand on your computer if you can. I guess you can verbally say, please send it forward. And we will do a quick little tally of votes. I'm not taking the silences of virtue of anything in this vote. Scott Legore: Would you just want to ask the services that are on here? Will Rosenberg:

Yes, we can just ask the services going around here if you wanted to go forward or stop. Scott Legore: For or against. Will Rosenberg: “For” is sending it forward and “against” is making some revisions for whatever reason before we send it forward. John Damiani: Make revisions. Against. Tyler Stroh: I’m for moving it forward. Justin Webster: We are for moving forward. Justin Kram: I’ll refer to Mark’s response. Mark Buchholtz: I think there needs to be some revisions. Jonathan Siegel: We’re fine moving forward. Mary Bell: Heart to Hart, we are for moving forward. Zach Risoldi: Would like to see a revision. Donny DeGraves: I’m fine with it moving forward. Matt Larrabee types: Move forward. Teddy Baldwin: Move it forward. Jimmy Pixton: Revisions. Jeff Kreimer: I think we’re going to abstain. Steve Rawheiser: Move it forward. Md ExpressCare: Revise for public record. Taylor (iCare); Revise it. Will Rosenberg, for Butler: Revision. Scott Legoe: Eight “for”, Eight “against” and one abstain. Will Rosenberg: I’d say then the motion to move forward fails if it’s a tie. So back to the drawing board it goes. Scott Legore: With that, I need to know what your thoughts are on the revision so that we can take that back to the drawing board. Will Rosenberg: So, the eight people that want to revise, if you could just let us know if it’s the nurse-nurse that you care about or do we care about the disciplinary process. I don’t remember who the people are that voted against it is, so just speak up. Mark Buchholtz: Discipliary process for ProCare. Scott Legore: Just shoot me an email and what you would like to see in it because the disciplinary process is going to be hard to define in a waiver regulation. I don’t want to speak for Claire, but we’re probably going to have to look at the entire section for the waiver and create its own section within the regulation to accurately define a disciplinary action and that’s going to take some time. Claire Pierson: Disciplinary process. When we all voted on this and went forward to the EMS board a couple of months ago, it was sort of a tradeoff. The expansion of the waiver was something the MIEMSS folks felt comfortable with and there was some sort of ability to put a stop to an individual driver. I guess we’d have to see what the board or other folks think about the comfort level with expanding apps with just cutting out that language. Will Rosenberg: I know Jimmy is concerned about the nurse-nurse and EVO waiver. I don’t know if you’re also about the disciplinary process or not? Jimmy Pixton: Yes, but I understand the complexity of it. So I’m not so much against that. I don’t like giving that, but I understand it because there’s nothing else to protect against it except you should go to the PSC. I think that over time, we need to set out a new way to do the whole thing. My biggest thing is that big loophole for the nurse-nurse not to have a non EMS driver. And I think that Dr. Chizmar agreed that needs not to happen. Dr. Chizmar: I agree on both fronts. My interest would be in closing both loopholes. And I guess on an interim basis, if you don’t move F9 forward, which I think is the driver issue, then you basically said that you’re okay with somebody that’s got a compliance issue being allowed to continue to drive as a non EMS driver. Jimmy Pixton: It’s the way it would be

perceived. It's just not the case. We don't know who the director is going to be in five years. They could come in and you would be giving that somebody that kind of discretion. Dr. Chizmar: I get it. I am just saying in the meantime, if there is some particularly egregious case, Scott is going to have to have some kind of recourse or somebody is going to have to have some type of recourse to prevent because we don't even know how long the PSC process takes to play out and they may not have summary suspension capability. So, just food for thought, as you and the other people that voted for against it, please give us your thoughts on both items. Both items should be address. Plus, to Scott's point, this should be moving forward in a manner to codify things and eliminate the waiver. Thus, the dual waiver dilemma may not solve a future problem. Claire Peirson: Can I just ask a questions, Will? Is it just a semantics thing, like "sole discretion" language that is problematic? If that particular phrase were removed would you feel more comfortable moving forward? It wouldn't change the use of the "discretion", but if we remove that, so it would still have that discretion? I think we were trying to make that clear to everybody. But if it's that particular language that you don't like so that you can make some sort of argument later, should this arise, we can certainly remove that in its discretion phrase. Will Rosenberg: So if I am speaking for myself, only my service look if they're that much of a jerk, we don't want you working for us so I don't personally care. But, as I speak as the chairman of CASAC, giving the director of SOCALR "sole discretion" is a very dangerous technique. You could argue legally that if it's not "sole discretion" that it is subject to review whether that's by Dr. Delbridge, or an AHJ, or what have you, or OH. I mean, I personally would be okay with moving "sole discretion", with a commitment from MIEMSS that we're going to revamp that language in future changes, maybe a whole new 15 or whatever. That's solely speaking from our service. I don't want to speak for the other seven services. I think you've got to solve this problem. This may be a stopgap measure, but my fear is that you decide you want to go back to MDH tomorrow and then we have to restart this process. The COMAR changes have been a slow roll at MIEMSS for many, many years. Claire Peirson: I'm not going back to MDH any day, but I hear you and I understand what we need to do. We are, as Scott said, have already started to meet to overhaul. I understand this is a priority in that process. Will Rosenberg: Any other services want to speak on this matter, please? I'm not sure we've given Scott or Claire a clear direction. So if you don't want to publicly say it, I'd encourage you, over the next two or three days this week, to send an email to Scott or Claire, or both preferably, and let them know your thoughts so they have some kind of direction and they're not just flapping in the wind.

New Business –

Anne Arundel Community College – Scott Legore

Anne Arundel Community College is working on a Commercial Services focused EMT Course and they are looking to pitch that to this group. It's doesn't look like they showed up today. I think I sent the flyer out. If your service would be interested in something like that, please reach out to them or reach out to me. I can forward you their contact information. I don't have a lot of information about it other than what they flyer said.

Medicaid – Scott Legore

Dr. Delbridge asked me to pass on some information. There was some concern from at least one service about Medicaid requesting separate NPI numbers from each physical location for the commercial services. Dr. Delbridge did some calls and finally nailed down someone at Medicaid and determined they are not requiring that information. It was basically a miscommunication between the service requesting the Medicaid information application and Medicaid. They basically thought the ambulance service was a doctor's office that had multiple locations and was going to be billing separately. So ambulance service do not, are not required to have NPI numbers, separate NPI numbers for each location if they're making the application for Medicaid. As long as the ambulance service is billing from the same location, the fact that it has different stations or outposts or bases is irrelevant. Will Rosenberg: For all the bad press we give MIEMSS, this is one case where MIEMSS actually went to bat for this service. The division chief of medical assistance came out with their attorney to some hospital system that may or may not exist in the state and told them under no circumstance were they going to bend on this. They were going to need multiple NPIs and less than 24 hours later, after Dr. Delbridge had a conversation with someone at MDH, they called the alleged hospital system and said that they misinterpreted their own regs and they were willing to see it the other way. So, like I said, Dr. Delbrdige and his staff really went to bat for this commercial service in question. Thank you and kudos. Dr. Delbridge: You're welcome.

Regulations – Scott Legore

I already mentioned that we have stated the process internally to look at 30.09 and try to clean that up and bring it to 2024. It'll probably be 2025 before we get this forward, but with that being said, we are asking if you have any specific sections that you would like to see changed, updated, or modified, please shoot them to me or Claire or both of us. Not just "Hey, I want this section changed." Please include some recommended language you would like to see in it and some justification for the change so that we can try to package that. Our thought process is that we will probably try to package the non-controversial ones all together so that we're not going to the EMS board every other month with regulatory changes. If there is

some controversial ones, we would like to take time to discuss them and work them out before we move forward. No time frame on this because with regulatory changes there is a limited window. It's been awhile since some of these have been done, so it's going to take a bit of time. Open to hearing your thoughts. If needed, we can schedule some meetings to discuss or include it in a CASAC meeting. We'll see how it goes as we move forward.

CASAC Positions – Scott Legore

Just a reminder that next month the chairman and vice chair positions have to be voted on. Will Rosenberg: If you're interested in a nomination, please send someone to nominate you to the November meeting.

For the Good of the Committee - None

Will Rosenberg: Any other topics, any other old business or new business? Thank you all for the first time in a long time for the spirited conversation.

Adjournment

Motion to adjourn by Tyler Stroh, seconded by Matt Larrabee. Meeting adjourned 13:53 hours.

Attendance:

In Person: Will Rosenberg, Scott Legore, Dr. Tim Chizmar, Donna Geisel, Jill Dannenfelser.

Virtual: Dr. Ted Delbridge, Jimmy Pixton, Matt Larrabee, Claire Pierson, Jonathon Siegel, Jeff Kreimer, Teddy Baldwin, Justin Gebhard-Kram, Leigha McGuin, Kate Passow, Mary Bell, Rob Weiss, Taylor D'Agostino, Donny DeGraves, Mike Williams, John Damiani, Justin Kinsey, Mark Buchholtz, Marty Johnson, Mike Moretti, Steven Rawheiser, Tyler Stroh, Zachary Risoldi, Abby Butler, Dylan Seese, Justin Webster, Rob Weiss, Sarah Pysell, and Steve Hoffman.

Callers: #1 – Dr. Tim Chizmar
#2 – Bobby & Jimmy Harsh
#3 – Scott Barquin