CASAC Meeting
Minutes – November 20th, 2024

Meeting called to order by Chairman Rosenberg

Approval of minutes – the minutes from the September meeting were sent out by SOCALR.

Are there any additions or corrections to the minutes? None
Motion to approve: Jonathon Siegel, Seconded by Jill Dannenfelser.
No objections to the motion – minutes approved.

State Medical Director's Report – Dr. Tim Chizmar

Education – Dr. Chizmar

As all of you will remember, the EMT renewal is a topic that we had endeavored to modernize last year. We solicited feedback on the new EMT renewal process. Essentially, the EMT renewal process has been the same at least for two decades, if not longer. You can renew EMT currently in a couple of different ways. You can do four hours of medical, four hours of trauma, four hours of local option, and a skill session. You can do a 24-hour refresher. You can do a company skills checkoff. It's sort of been roughly the same and what it leads to is that we have not done the best job with keeping up on continuing education for the EMTs that are not nationally registered out there. Obviously we are not changing that component. We want to be really clear, we're not endeavoring to require people retain their national registry EMT card. Certainly they're welcome to if they would like to. Probably allows for better job mobility, but if you follow our con ed pathway from the past you'll notice that you could do the same four hours of medical, the same four hours of trauma, the same four hours of local option every single renewal cycle and it doesn't lead to any improvement in our EMT's knowledge skills and abilities. We are committed to keeping the number of continuing education hours for an EMT at 24. That's where it's always been. The maximum is 24 hours. So 24 hours every three years or about eight hours a year is the minimum. Certainly if people want to do more than that or they want to maintain their national registry EMT, they have to do more than that. They have to do 40 hours every two years. Initially we had proposed doing 20 hours of didactic education. The feedback that we received from many across the state was that EMTs often times need a little bit more extra TLC when it comes to technical proficiency or skills. And the ask was not to just leave two or three hours allotted for the skills. What we've come up with, what Dr. Delbridge has presented, and I'm seconding to the board, is a model that would keep it at 24 hours, instead of 20 hours of didactic, go down to 15 hours of didactic. In those didactic hours, we would spell out three

years ahead of time what the breakdown of the hours are. So you would know if you recertify in 2027, you would know what the hourly distribution of medical, airway, trauma, et cetera, is three years in advance. And then the remaining nine hours, up to nine hours, could be dedicated to technical proficiency evaluations, skills evaluations. If you only use one or two of those hours for skills, we would essentially ask that the student backfill with additional didactic education. So, for instance, if you do the 15 hours and it takes two hours for Butler to sign off that you're competent with your skills that would bring you up to a total of 17 hours. You would still have to complete seven hours didactic education to complete. In the public safety world, I think more likely than not, the education programs are going to probably use most of that full nine hours because what we've seen is what when we bring EMTs back in every three years, they need to be re-educated in certain infrequently used skills. They usually do fine with placement of airways, they usually do find with things that are common every day, but things they're not using every single day, they need a little bit of re-education on. The last component of it has always been there, we've just left it to the commercial services and jurisdictions to police. That are the annual protocol reviews. So at least every three years, if your clinician has not completed the past three years, we're not going to renew their EMT certification until they do. So certainly if you want to do it, I would encourage you to do it every year, but we'll catch them every third year if they're not doing that. So Randy has go the screen up. I am much more of a visual person, but this shows you the side-by-side comparison of everything that I just described verbally. So maybe it's appropriate that we pause here and get questions, comments, and give people a second to take a look at it. The old is on the left. The new or proposed is on the right. And Claire, I'm not going to throw you under the bus, but as far as timing goes, I know we can't drop regs during the General Assembly session, so I'm not sure exactly what he has in mind.

Clair Pierson: Actually this year we can. They have removed the moratorium, although we don't know what it's going to look like in terms of speed going through.

Dr. Chizmar: Whether it goes forward during that period or not, the take effect date was projected out to be July 31st of 2025.

Claire Pierson: I think that's still the case because I don't think we want to promise anything earlier when we don't know.

Dr. Chizmar: Questions. Comments, concerns from the commercial ambulance group advisory committee?

Will Rosenberg: Anyone on Team Zoom, whatever we're using? Want to comment?

Randy Linthicum: There's a second slide Scott. If you want to show that, if there are no questions on this.

Dr. Chizmar: Scott, if you have that second slide up and I think you'll actually like the second slide better. I think you'll like the first bullet there. Currently 30.02.02 requires a fee from clinicians that are employed by only

a commercial ambulance service. This would remove that or waive that fee. 30.02.03 is some cleanup around protocol orientation. Currently people coming in from out of state, 30.02.02 and 30.02.04 requires that they take a 12-hour skills session. This would clarify that to provide an orientation. Work orientation to the protocols particularly, which is something that we've already started to do through the online system. Providing an online protocol orientation for the initial license. But this would get rid of that skills requirement and also get rid of the 50-question protocol test that we still have here at MIEMSS. 30.02.05: Currently the National Registry allows you six attempts at the NREMT cognitive exam. However, the psychomotor exam, which is administered by MIEMSS, only allows you three attempts. If you fail three times, you have to go back and take the entire EMT class over again. This would remove that regulation, and it would give you up to six chances to attempt the psychomotor exam. And if you're unsuccessful, would direct that you take something less than the whole EMT class, some portion of the EMT class that would get you back to being able to be more successful in subsequent attempts. So perhaps the last part of EMT class, but not the entire 200 plus hours. And Randy and Scott, help me on 30.02.07. The slide is bland there.
Scott Legore: It just says renewal update.
Tyler Stroh: Referring to what you just talked about on the other side.
Dr. Chizmar: I'm not entirely certain these are the high points. I think 07, as Tyler was saying, may actually reference in detail what we showed you on the prior slide. Those are really the high level things: removing the fees, making it more straightforward for reciprocity, and making it more reasonable for people who are unsuccessful with the practical or psychomotor exam. Hopefully things that are positive changes. We're certainly open to feedback now or later through Scott. If you have feedback, concerns, or questions you can send an email to Scott Legore.
Will Rosenberg: Anything? Anyone?
Donna Geisel: With National Registry, after three failed attempts, I think they make the EMTs do a refresher, not a full course. So is that something that we could apply into ours, that they do an EMT refresher?
Dr. Chizmar: Yeah, that's what essentially they're doing, is asking them to take the skills-oriented portion of it.
Donna Geisel: Not the full 24 hours?
Dr. Chizmar: Not the full 24 hours. But it specifically says in the Maryland reg, if you fail it three times you have to take the entire thing over again.
Will Rosenberg: 30.02.07 is summary suspension of licensure certification.
Dr. Chizmar: I will tell you these are not my slide set, but I will tell you that these are the content of what we're looking to move forward.
Will Rosenberg: Alright, I think we have no more comments or questions on the COMAR amendments.

Protocol Review Committee – Dr. Chizmar

The Protocol Review Committee wrapped up its last formal meeting for the year on Wednesday, a week ago. I know that we had some preliminary discussion and Scott Legore & I looked at one of the products regarding video laryngoscopy.

Video Laryngoscope – Dr. Chizmar

One of the things that commercial services would be the video laryngoscopy requirement, moving from OSP into a standard equipment for ALS, obviously not for BLS units. Not to endorse any particular product and we don't want to come off as endorsing any particular product, but Scott and I have reviewed several different products. We actually had one come here to the office and I had the opportunity to trial that is quite reasonable. Scott, if you want to chime in on some of the price points and what we found, please go ahead.

Scott Legore: It was recommended by one of the services at the last meeting. We purchased it and reviewed it. It was the iView single-use disposable video laryngoscope and it's by Inner Surgical. And the cost, we paid $179 for a single device. I'm not sure if you purchase in bulk whether it will be a cheaper price or not, but it was $179 for a single device.

Dr. Chizmar: Just to review with everybody that may have not been on the call, we have had an OSP, an optional supplemental protocol, in Maryland for video laryngoscopy for paramedics that has been around the better part of a decade now. There's been a trove of literature on the topic and obviously we're not intubating as often as we used to. One of the things that has been shown is that having a tool at your disposal is very helpful in helping the paramedic, particularly a paramedic who's not intubating frequently, secure the airway when minutes count. When we first put this into play, the video laryngoscopy devices were not so portable. And the price point was around $8,000, $9,000, and $10,000 in some cases. So as time has gone on, as the literature has evolved, one of my changes is to try to not leave things in optional supplemental mode if there's good evidence to support its use across the board. I do realize that there's a fiscal impact. We're required to let the board and SEMSAC know about fiscal impact, required to let you know about fiscal impact, and I wouldn't be coming here soliciting feedback if I didn't think it was important. I realize that in commercial services you're not intubating as much as they would in the public safety world. But frankly, that also makes the argument even more strong because you're not getting those unless people are working in dual roles, and you're not necessarily getting those reps with the airway. So I'm currently open to feedback on this. I want, as Will, Jimmy and others who have been here for a while can attest, we have whittled down the inspection sheet from enough equipment to take care of two patients down to one. We've whittled it down and I'm committed to whittling it down and not having to carry in an excess of supplies, but there are certain things like airways that we need to be able to manage. And

yes, we can call upon 911 to help us in certain instances, but these are ALS licensed ambulances that are out on the streets in Maryland. Several of you have 911 contracts, and those of you that don't are using those ALS ambulances to become SCT ambulances in some cases. I'm biased, but I, for one, think this is a very reasonable move. Hopefully, we've dealt or mitigated some of the cost concern that we had at the last meeting, but I'm happy to have discussion now. Will, if it's appropriate.

Will Rosenberg: It now seems like a good time as any. Any thoughts from the group?

Tyler Stroh: Do you know what the shelf life is on these devices?

Dr. Chizmar: Scott, we looked at that. Did that have a fixed expiration date on it?

Scott Legore: I don't know the answer to that question. I believe it was a five-hour battery life.

Dr. Chizmar: It was multi-year. I don't want to misquote it and say two or three. But Zach Rosoldi has those already. I think Zach was the one that put the comment in the chat.

Donna Geisel: Want me to go get it?

Dr. Chizmar: Yes, if you want to grab it. It was a multi-year time. And I think Zach put in chat that he gets his for $90 apiece. Was that right, Zach?

Will Rosenberg: He says it's not going to expire until 2029. I guess that makes it five years.

Dr. Chizmar: Not that you'd have to buy that product. We're just trying to find an inexpensive option for people to still have access to the technology and not break the bank.

Zach Risoldi: I just wanted to point out one thing which is that if there's regulation in the OSP that says video or recording is a necessity, these devices do not record.

Dr. Chizmar: I think that's one place probably where I differ from my predecessor. I think it's desirable for those that have medical directors that want to review them. I think it's helpful. But if that is a barrier, I think we should be willing to set that aside if that's the barrier to entry here. In other words, I'd be willing to set that aside for the purposes of commercial. I certainly would encourage you to have it but we're not going to require it. While you are thinking of the questions on that or comments or concerns, the PRC has otherwise been very busy.

Protocol Review Committee continued – Dr. Chizmar

There are two new medications that are proposed. All this is proposed. None of it has gone through the SEMSAC. None of it has gone through the board. One of which is Cefazolin. I would not see that as applicable to commercial services. It's Cefazion for open fractures. Generally speaking, you're going to be transporting people from a facility. If they've not received their Cefazolin or their antibiotic before transport, then the

hospital can hang it and you can monitor it. I don't think we would need to have it stocked on a commercial ambulance service unit.
The other one is relevant because it could affect the level at which you run the call. We did approve Labetalol for an indication for hypertension in pregnancy. Currently because it doesn't fall in the ALS protocol, it automatically becomes SCT. We've approved if for a very narrow indication, which is hypertensive emergencies and pregnancy, preeclampsia, and eclampsia. It is a very inexpensive medication. Obviously it's been generic for a lot of years. What the 911 services plan to carry is a hundred milligram vial, which would get you all the doses and all the repeat doses and so forth that you would need to treat a pregnant patient. I realize that not many of you are treating gravid patients and there's a requirement for a nurse going between facilities with gravid patients, so I wanted to bring this to your awareness. I really don't think we need to have it as a requirement on every single ALS unit, but I do think it's probably relevant for SCT units to carry it. Questions, thoughts, or comments on that, because COMAR requires you to take a nurse with you on patients that are more than 20 weeks. All of the preeclampsia and eclampsia women will fall into that category, so you're going to have the nurse there anyway.
Will Rosenberg: Would you say you want to change that regulation and that we can carry the bill? That sounds like a great plan.
Dr. Chizmar: I didn't say that.

Video Larynoscope continued – Dr. Chizmar

Will Rosenberg: It is a shelf life of five years by the way for that product. I looked it up since we didn't have the packaging.
Dr. Chizmar: We can pass it around. For those of you that are at home, this is an advantage to coming to the meeting. You get to handle the equipment. You get to have show-and-tell, probably be intubating Tyler here shortly. Make sure you turn off the cameras. (laughter) So, come in person next to the next meeting. In the interest of everyone's time, I've taken up enough of the meeting. If there are comments, questions, or concerns for me in general, I'm happy to take them.
Will Rosenberg: Anything for Dr. Chizmar? I'll take the silence as a no. So we'll move forward to SOCALR.

SOCALR Report

Inspection/License Update – Marty Johnson – No report.

Renewals – Scott Legore

We finished up the renewal period. We still have about 20 units or so that are still outstanding that did not make their renewal inspection. We will knock them out as they become ready for service.

QA Review/Data Import – Scott Legore

Scott Barquin is working with several services on their data imports. I saw some emails just prior to the meeting.
Scott Barquin: Just ongoing issues with crew configurations and getting clinicians affiliated.
Justin Kinsey (Traumasoft): Some services read the meeting minutes from the previous meeting and had questions about the conversation regarding the suffix of the agency ID number being added to run numbers and I just wanted to see if there was any formal decision that was made on that or any other communication that had gone out so that we can intelligently answer these services that are inquiring of us?
Scott Barquin: Apparently, that's on hold. We received quite a bit of pushback for making that implementation. We are working with ImageTrend to see if it is possible for them to do it in the background. But so far, we have found that it is not. So more to follow, but currently it's on hold.
Justin Kinsey: Thank you very much.

Equipment Update - Scott Legore – Nothing new to report.

Smartsheet – Scott Legore

If you haven't noticed, we added one more widget to everyone's dashboard. It shows who you named as having access to your dashboard. That way it will be a quick reminder if someone leaves the service that they still have access. That information is shown in the upper right hand corner of everyone's dashboard.

Clinician Services – Aaron Edwards – No report.

Aaron Edwards: Aaron Edwards, new to the position, and have been here for a little over a month now. Came from 911 down in Annapolis. Annapolis City for 30 years and have actually learning a lot more about SOCALR. I was supposed to meet with Scott Legore today. We were going to have discussion, but he wasn't feeling well. I am looking forward to meeting with him in the near future. If you have any issues or any questions, I'll make sure Scott gets my email and information out to you.
Will Rosenberg: Anyone have anything for Clinician Services?
Dr. Chizmar: His email address is aedwards@miemss.org.

Committee Reports

SEMSAC Report – Danny Platt unavailable, Will Rosenberg

Will Rosenberg: Dany is unavailable due to a funeral, but he sent an email. Two things from SEMSAC: 30.02.02, which you've already talked about getting rid of the commercial amnesty fees for licensure and there were some discussions regarding a compact agreement similar to what

nurses have for those who are familiar with surrounding states. Discussion was tabled and most felt, including himself, it was not necessary because Maryland is already an easy reciprocity process. EMSCompact.gov. There are 25 states (24 or 25 states) and we are surrounded by them, so the question is started to be posed. There are definitely pros and cons to it.

Dr. Chizmar: I think if people take a look at compact, and I think we're interested in the feedback from all different angles on that, it may be a topic that comes up in legislative session. It requires the passage of legislation. So, if you're not being asked here, you may be asked during the legislative cycle. I don't know that to be the case for sure. I guess, you know, the other component is that within that legislation requires several other things, including background checks. It would essentially not require people to be licensed in Maryland. There licensure would be held in their home state. The only information you might get about that person is what's in the National Practitioner Data Bank, which most of our QA stuff does not go into the National Practitioner Data Bank. So you can imagine that the pool of clinicians might be wider and more available for you to hire, but you might know less about them depending on where they're coming from. So I think it's a real complex analysis. And I do think if the question gets posed, we will want to know from all the stakeholder groups where you stand.

Will Rosenberg: So I'd encourage everybody to do a little research, a little soul searching, and we'll leave it under old business for the January meeting to discuss a little bit further.

PEMAC Report – Jill Dannenfelser – No report.

MIH Report – Deb Ailiff (Not available) Justin Kram – No report.

Old Business

Video Laryngoscopy – Already discussed.

Non-EMS Driver Regulations – Scott Legore

After last meeting's discussions we went back and made a minor change to F(9) which is what shows here at the bottom of the screen (displayed), "Continued to use a non EMS driver that SOCALR has determined , in conjunction with the MIEMSS Office of Integrity, to be a threat to the health and safety of patients or the public". We added "in conjunction with MIEMSS Office of Integrity" based on the conversations of the last meeting. Then the other discussion point was not to allow the Nurse-Nurse Waiver units to utilize a Non EMS Driver. There's really no place for it to be spelled out in the regulation itself. However, we have the administrative authority to, as we issue the waivers, to put that language in the waiver itself. We felt that was the best place for it. We don't believe it

needs to be a regulation because the regulation doesn't specify any specific waivers other than the non EMS driver, which is kind of spelled out, but the other Nurse-Nurse Waiver is not specified. That is just one of the various waivers that we issue.
Will Rosenberg: So we will take comments.
Scott Legore: So the question is, does that satisfy the group? Are we ready to move this forward and back to the EMS Board for their consideration or is there more discussion?
Will Rosenberg: I just have a question. I guess implied in the word continued to use a non EMS driver… was there a reason why we put continued in there instead of just using a non EMD driver?
Scott Legore: Yes, the thought was that we would make a request for the service to stop using them. If they continued to use them after we made the request then that would be one of the reasons we could suspend their waiver.
Will Rosenberg: I guess I see that since this is a service oriented piece of the regulation.
Julian Clark: I have a question. Is this only pertaining to those non EMS drivers that may have faced disciplinary actions or is there anything in this criteria that we should know about?
Dr. Chizmar: I think it's probably primarily disciplinary action.
Scott Legore: It was disciplinary action. This really has to do with a concern brought by the Office of Integrity whereas the prohibited conduct that applies to EMS clinicians technically is not enforceable by her office, so we need some way to enforce that on the non EMS drivers and that this was the way we were trying to close the loophole that we thought was there.
Will Rosenberg: The example given was an EMT is on suspension from the Office of Integrity, they can become an EVO and the PSC hasn't even found out about it because it's not a criminal matter, it's a conduct matter. The screens are for criminal offenses, not EMS conduct.
Dr. Chizmar: MIEMSS cannot regulate people who don't possess an EMS license, which these guys don't. So they only way we have to protect the public in this case would be to ask the service to not use the person, and then the service says no, we still want to use this person. Then SOCALR would decline to keep the non EMS driver waiver.
Julian Clark: Great, thank you.
Will Rosenberg: Any other comments or questions about the proposed change? Scott, do you need a motion to move it forward or just a radio silence to move it forward?
Scott Legore: Think you probably should have a motion due to all the discussion at the last meeting.
Will Rosenberg: Claire agrees. The attorney in the room says I need a motion. So can I get a motion to recommend this move? Matt Larrabee put in motion. Tyler Stroh seconded the motion. We got a motion on the floor. Any discussion? Any extensions? Motion carries.

2025 Schedule Meeting Dates – Will Rosenberg

Scott Legore has sent those dates out.

Scott Legore: The one change was the March date which was moved to March 25th to accommodate another conference that the services attend. The meetings will still be on the third Wednesday of the odd months. Will Rosenberg: There are some hard copies of the schedule here if any needs to pick one up.

Photo Collage – Scott Legore

Scott Legore shared a photo with the group. We mentioned before about creating a photo collage. This is what we have so far. It is a very basic version. I know there are some pixelated pictures in here that we are still trying to clean up, but this is kind of what we're looking for.. a layout of pictures of all the services in Maryland. We still have some services that haven't submitted pictures, but this is our first draft. Just wanted to throw it up here so everybody can see what we're looking to do.

New Business –

Election of Officers – Will Rosenberg

The only new business we have is the election of officers. As you know, the chair and vice chair serve a two year term, which ends this December 31st. This means this is our last meeting of the calendar year. We have to have an election of officers. Normally we do this by secret ballot in the room. But since there's four of us in the room, I don't know how Scott was planning on doing this.

Scott Legore: We have to have nominations.

Will Rosenberg: Yes, we obviously have to have nominations but I was getting more to elections and there was only four of us in the room to vote.

Scott Legore: The four in the room would vote and those that aren't in the room would email Marty Johnson directly and he could tabulate the votes. I have the list of who's eligible to vote up on the screen.

Will Rosenberg: Okay, we will take nominations from the floor, and from the TV. We will start with the chair.

Tyler Stroh: I'll nominate you, Will.

Will Rosenberg: Look, I got nominated. Any other nominations for chair? We'll call nominations closed. Nominations for vice chair. Don't all jump at once. You can nominate yourself, it's okay. I'll take a nomination for vice chair from anybody here at this point in time. It's the easiest job in the world. There is a nomination for Tyler Stroh. He accepts. Any other nominations for the vice chair? Nominations for vice chair is closed. So you can email Marty or give Donna a piece of paper with your vote. Given that it only takes one vote to pass, I think we're pretty safe to move on. So any other new business?

For the Good of the Committee - None

Adjournment

Will Rosenberg: Take a motion to adjourn.
Motion to adjourn by Tyler Stroh, seconded by Matt Larrabee. Meeting adjourned 13:53 hours.

Attendance:

In Person: Will Rosenberg, Dr. Tim Chizmar, Donna Geisel, Abby Butler, Rudy Vedder, Julian Clark, Claire Pierson, Tyler Stroh, and Aaron Edwards.

Virtual: Scott Legore, Jill Dannenfelser, Jimmy Pixton, Jonathan Siegel, Justin Kinsey, Justin Kram, Marty Johnson, Mary Bell, Randy Linthicum, Scott Barquin, Zach Risoldi, Ashley Holston, Brian Barnett, Chenelle McQueen, Donny DeGraves, Joel Atwell, Justin Webster, Kate Passow, Matt Larrabee, Mike Moretti, Stephanie Ermatinger, and Teddy Baldwin.

Callers: #1 – Mike Williams
#3 – Lindsay Leach