**CASAC Meeting**
**Minutes – January 15th, 2025**

Meeting called to order by Chairman Rosenberg

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

Are there any additions or corrections to the minutes? None
Motion to approve: Mark Buchholtz, Seconded by Matt Larrabee.
No objections to the motion – minutes approved.

**State Medical Director's Report** – Dr. Tim Chizmar

2025 Protocols – Dr. Chizmar

Dr. Chizmar: As all of you are aware we wrapped up the protocol cycle for last year. I did not take time at the joint State EMS Board and SEMSAC meeting today to present those to the board. That will be on the State EMS Board meeting's agenda at the next meeting. Very briefly, I would like to cover some of the things that I anticipate presenting to the board, such as an alcohol withdrawal protocol that specifically calls out patients that are experiencing alcohol withdrawal, treating them with midazolam, and it's pretty straight forward I think. In no particular order, from pediatrics they are proposing the distal femoral site for the IO in pediatrics for intraosseous infusions. The reason we did not put that in for adults, very briefly, is that it does not have an indication from the manufacturer for the distal femoral site. I know it's possible to put an IO in the distal femur in an adult, but it's not approved for the EZ-IO, which is what a lot of services use. And frankly, you have three other sites in adults. And with trying to get through adult musculature, I don't really see the value in the distal femur site. That will be, again, subject to board approval. This does not affect commercial services all that much, but we will be making, just for situational awareness, some comprehensive changes to the drowning protocol that'll incorporate termination of resuscitation more often than what we are doing now, which is transporting all drowning patients, whether they were witnessed or unwitnessed. There will be a change upward from pediatric in the dexamethasone dose. Obviously, we'll summarize all of this information for you. I just want to make sure to cover this in a couple of meetings with folks. A change upward in the maximum does of dexamethasone from 10 milligrams up to 15, one five milligrams is the max. That was brought to us from PEMAC and is sort of the broad consensus from the pediatric community. And then on the field side, and I can't see how it would impact commercial services, we will be looking to put in Cefazolin for open fractures. So patients with open fractures in the field, or at least suspected open fractures, can receive one gram of Ancef,

or cefazolin, to try to reduce the risk of infection. Again, with pregnant patients, we're also advancing the Labetalol protocol, so antihypertensive treatment with Labetalol, from patients experiencing preeclampsia or eclampsia, along with magnesium on a more preventative basis, it's not just for eclamptic seizures. So that will be coming soon. I think in the commercial services world many of these calls, if they're identified as preeclamptic or eclamptic are going to run at higher levels of care at the SCT level. But I'm certainly open to your feedback as we kind of walk through and talk through with any implications to the commercial services or IFT world. And that is really the high level summary of what some of the protocol submissions for this upcoming year are going to entail. Also on the protocol front, we had a discussion, mostly by email, about how we handle tracheostomy patients. And it long precedes me that the protocol for transporting a tracheostomy that's over seven days old was to send them by a minimum of one BLS and then a second person of either a trained family member or a second BLS clinician. With the advent of the non-certified driver, that's become a challenge for some services to come up with the second BLS clinician. Used to be that we ran BLS units EMT and EMT, so that was automatically met. In conversation with a couple of folks on CASAC, a lot of us have really come to the realization that for better or worse, we have not spent significant time in training, either initial training or ongoing training with EMTs regarding how to handle tracheostomies and emergencies that may crop us. And quite frankly, there are several in the group that support not having that go BLS at all. They favor the minimum staffing for a patient with a tracheostomy to be a paramedic, or at least at the ALS level, so CRT or paramedic. Just given the increased emphasis on airway management so I wanted to, if it's appropriate, to talk through talk or if you want to talk through in new business we can talk through it then. I do want to point out that some representatives did send something and I don't know if anyone's on here from LifeStar to speak on his behalf. Teddy, do you want to speak on Danny's behalf and then I'll open up the floor.

Teddy Baldwin: Basically our thought was that we kind of go opposite of what it sounds like some folks are saying and moving that to ALS is that we allow it to go with the non-EMT driver and the EMT on board. I mean, we, just in 2024, did over 34,000 transports on the Maryland side and 192 of them are trach patients sent BLS. So while it's a small number, it's still, you're putting an ALS truck, in our opinion, out of service for essentially no good reason for patients that have always gone with a BLS provider. So that is kind of where we stand on it. We'd like to see it stay BLS and be allowed with the non-EMS driver.

Will Rosenberg: Just to close the loop on behalf of Danny, these are not my personal thoughts these are Danny's. He said he would either like to have non-EMT drivers added to the definition of clinicians or the airway management protocol to no longer say two clinicians. That was his two suggestions.

Dr. Chizmar: While I can't speak directly on that, that's probably a combination effort on the non-EMS clinician side. I think probably, and I'm not trying to be cutesy here, but probably implied in the name non-EMS clinicians is that we don't license them and that we can't, they're not medically trained to the point where we can expect them to do anything medically oriented other than lifting the person. I don't think that would be fair to start assigning them medical tasks without some level of licensure or training. It would be exceedingly challenging for me to understand how we would incorporate that into a licensure level.
Will Rosenberg: Just for clarity under his position, again, Danny's, not necessarily mine. He's talking about in the definition of the Maryland State Protocols.
Dr. Chizmar: Maryland State Protocols only apply to people that MIEMSS license. I mean, that's sort of the scope of the Maryland State Protocols is to apply to EMS.
Will Rosenberg: Yes, I totally get it. I guess I am trying to address this for the group then.
Dr. Chizmar: We come into this when we start talking about nursing care, critical care, and physician level of care. Medical protocols are written for people that have MIEMSS licenses. So those would be obviously EMR, ED technically, EMT, CRT, and paramedic. And SCT paramedics are obviously included in that.
Will Rosenberg: Looks like Mr. Pixton has a question.
Jim Pixton: So what about the trach patient at home where they have a home nurse or a family member that does vet and trach and we take them to a doctor's appointment. But that's not ALS now?
Dr. Chizmar: That's what we've got in there currently and, frankly, you know those people tend to obviously be very knowledgeable. They know the patient and they probably have an extra tracheostomy. And, probably you know, they are the best suited to go with us, not to disparage anybody, but probably know more so than a paramedic who doesn't know the patient. So, to be clear, I wasn't looking to cut that out. There was a concern that the EMT, that is what's currently written down, which is either you have two EMTs or you have an EMT and the trained family member or person like you reference, was too restrictive. That if you are running a non-certified driver EMT model that it was too much to ask to have a second EMT join onboard for those transports.
Jim Pixton: Okay, so as long as we have someone trained other than the EMT, then we'd be covered, right?
Dr. Chizmar: Yes, that's the way it's currently written. What's on the table now is do we change that? If so, what do we change it to?
Will Rosenberg: As you heard, I think from Teddy, he would prefer you change it to less of a requirement so that it could go solo EMT or solo EMT would be the floor, put it that way. And then if obviously you had a trained person, you know, nobody's ever going to turn that down.

Dr. Chizmar: I guess to represent the patient's safety position, these are, you know, 99% of the time or some proportion of the time that's very high, the patient's going to go from A to B and not have any problems at all. The challenge is trying to identify those patients that are going to have challenges. I think we all probably can pretty much agree that that's a roll of the dice. You don't know when somebody's going to experience a problem. But are we putting an EMT in a position where they are doing something that they, that we've given them very minimal, if any, training on, and they have to try to manage that? I think if you went to the majority of the EMTs, Jim, whether it's your EMS or Will's or Teddy's, they would be lost in the sauce when it comes to trying to manage any sort of tracheostomy emergency.
Will Rosenberg: To answer the question of the person who put it in the chat, it is Procedures, Airway Management, Tracheostomy, Suctioning, page 270 of the Protocols. The screenshot I was given cuts off the protocol number, but its page 270 of the Maryland State Medical Protocols.
Dr. Chizmar: Procedures 12.10 and 12.11.
Justin Kram: We have it.
Will Rosenberg: Mr. Pierce
John Pierce: I have a question about the thought process behind two EMTs versus one EMT when managing. What is the thought process of having two EMTs equally trained? How is that different than one EMT trained? Do you know what I mean?
Dr. Chizmar: I'm trying to represent the thought process from the time that proceeds me, but the only advantage that I can think of with two EMTs is to have literally a second set of hands to manage the tracheostomy change if one needs to happen or the tracheostomy bleeder if that needs to happen or the otherwise obstructed trach that needs inline suction. I mean, frankly, and I think we're rolling the dice with EMTs because we don't spend sufficient time in their curriculum, either initial or ongoing. And I don't know that it belongs in the BLS curriculum to begin with. I think I can't represent this fairly, but I think this was probably a compromise that was made long ago where…
Jim Pixton: Medicaid, I'm the one who fought for this. So in Medicaid, because of how many these people that are home and we fought for that, it was probably two EMTs because back then we didn't have Non EMS Drivers, you know what I mean? So it kind of fell into place. But the reason this was done was because we used to transport a lot of vent kids with their parents or a nurse and we used to have to send ALS, which was ridiculous. It was ridiculous to send ALS to a doctor's appointment when these people lived on these vents.
Dr. Chizmar: I understand, Jim, and I appreciate that because I figured you may have been around for that discussion. And I guess I know that everybody loves Non EMS Drivers. I begrudgingly see the reason to have Non EMS Drivers, but what I can't really do is let the level of patient care

suffer, frankly, because of some sort of cost center. It is essentially the only reason that Non EMS Drivers are in there.
Justin Kram: I'll try to keep my comments brief, but it seems like this is a multi-faceted issue. So if we're making the assertion that EMTs in general aren't adequately trained to manage a tracheostomy, then if two EMTs who, for argument's sake, don't know what they're doing or versus one, what difference would it make? Second, why couldn't an EMT and a Non EMS certified driver enlist the help of a non-certified driver in a support role as a second EMT would be? And then my third thought is, if we believe that the EMTs aren't adequately trained to maintain the airway, one of the very most basic functions of an EMS provider in general, why isn't the focus more on training the EMTs to be adequately trained, either at the initial testing phase or during recertification so something like that? Why would we go backwards as far as standard of care in the protocols, regress, and then make it more onerous for that patient population, as well as the companies that have to serve them?
Dr. Chizmar: Yeah, so when the new EMT renewal came up I actually brought this issue up and I was going to put recommend that we put dedicated, you know assessment of tracheostomy management in the EMT renewal and the opinion of many in the EMS community, including the educators, was that this was too onerous on the EMT. Now, at the same time, we did not go back and look at this protocol that we're looking at now. And again, I believe we've made this decision based on cost and I will say if you put the average EMT out there with the tracheostomy patient and we are really being honest with ourselves, I think we are doing them a disservice by putting them in the back, alone with the tracheostomy patient. We're marginally doing better if we have a second set of hands to help them. Frankly, I firmly believe that the curriculum, whether it's the initial curriculum or ongoing, is just not sufficient to cover that. And unless there's an appetite to expand the curriculum, expand the number of hours, which I clearly don't see coming, then I think we owe it to ourselves to either, as Mr. Pixton said, send a trained person with the EMT. Or send them double EMT or send it ALS and a non-certified driver. And I think this is why MIEMSS probably didn't go down the non-certified driver for many, many years. It's a slippery slope. These are not medically trained people. This is what you're talking about doing, involving them in medical care when they have zero training whatsoever.
Claire Pierson: From my perspective, if we're going to start using non-certified drivers to provide medical care support role, then I think we're running down a slope real fast towards providing EMS in an uncertified fashion, or getting somewhere towards that line, and I wouldn't suggest that we sanction it in the protocol.
Will Rosenberg: Mr. Buchholtz?
Mark Buchholtz: So has there been any negative outcomes? I understand why we're reviewing the protocol, because we saw a conflict with it. Can we look at the data? Because we're transporting a lot of these patients

BLS now. And can we see how we're doing it? Are there negative outcomes and see what the data suggests?
Dr. Chizmar: Mark, I think you could ask that question but I don't know that the data quality is going to be there to answer it. And the other comment I'd have on that is the absence of negative outcomes is probably not the measuring stick by which I'd want to move forward on either. Because then when a negative outcome does come along, we're going to be backtracking and try to figure out why did it happen and maybe we should have done something ahead of time to prevent that negative outcome.
Mark Buchholtz: And we're going to increase the number of transports significantly from BLS to ALS.
Dr. Chizmar: Again, I wasn't coming out of this gate to up this to ALS. Although it probably makes the most amount of sense to do it. What was being kind of thrown out there was it was too much to put a second EMT on the tracheostomy transport. So clearly, if we put a second EMT or a trained family member on the transport, that would be in accordance with what's written in the book today.
Will Rosenberg: So real quick, before I come back to you Mr. Kram, I know Mr. Moretti just put his hand up. If you're not following the comments, there have been some comments that have come down. Matt essentially echoed the comments of other people. If you have one EMT that doesn't know how to do it, how is two going to make it better? Mr. Pierce asked if could amplify the training and Rob asked if we could make it an OSP. I'll pretty much tell you that's not going to happen. MIEMSS is trying to get rid of OSPs, not add them. They're never going to agree to that. So what I don't understand, Jim, and I'm going to ask you in a second, but I'll let Mike talk first "Who the heck thought of putting something in the only protocol in the entire book that says two EMTs?" Everything else is ALS or BLS. I don't know who dreamed this up. So Jim, that's going to be my question for you. So start thinking it up, but I want to let Mike talk first. Thanks.
Mike Moretti: I was going to say the OSP route, but you just answered that. But up here in PA, we probably do triple the amount of BLS tracheostomy patients and we are very successful with it. Part of our orientation program, we have a trach mannequin that we train all of our EMTs on. Obviously they can't do trach changes, but we teach them on trach maintenance and how to troubleshoot a failed airway. So if it's about the training, let's try to figure out how to train the EMTs to get them to where they need to be. Because really, if you have two EMTs that don't know what they're doing, it's a lot worse than an EMT that know what he's doing.
Will Rosenberg: Thank you Mike. Jim, I'm hitting you with a question. Before you can say anything else, you have got to answer the question: Why is this the only protocol in the entire book that says two EMTs?
Jim Pixton: I have no idea. Somebody must have thrown it in there. And we probably didn't push back because back then you needed two EMTs,

one to drive and the other to ride. I want to go back to Dr. Chizmar. I don't know why he keeps saying this was done for cost.
Dr. Chizmar: The non-certified driver thing was done to try to fill that driver role. But Jim, if we need to provide the appropriate level of staffing in the back, the non-certified driver was never meant to be somebody that got into the back for anything other than to lift the patient in and out.
Jim Pixton: Unless it's CPR. I mean, they're trained in CPR and first aid. I don't care about that. As long as we have the option of having a family member, a trained person, we should still be able to use an EMT and that trained person. We don't ever do it without another trained person, s it doesn't affect us in any way, unless you say it has to be two EMTs. I just didn't want anybody to think it was ever done about money because actually that would have been a state issue because they would be paying us double to do ALS versus BLS, so it's not a money issue.
Will Rosenberg: I don't speak for Dr. Chizmar, but I am going to try anyway. I don't think the intention was ever to remove or another qualified trained clinician. The concern, when Dr. Chizmar and I first had the conversation and Justin I'll let you speak in just a minute as I see your hand, was the sentiments that most of you shared is, what is two EMTs going to do to make it better than one EMT? And that was my question to him, because one doesn't know how to do it and then we have two that don't know who to do it. It's not going to make it any better. And I expressed my concern that most EMTs would not know how to change a trach because the protocols theoretically say you have to have a spare trach and be able to change it if it should become fully occluded or to replace it. I think suction is pretty basic of a trach. If we can't get EMTs to do that then we are in deep trouble.
Jim Pixton: Well, Will, they don't teach it anymore, just so you know. We just went through this with an EMT instructor. Suctioning now, we have to teach all our new EMTs how to suction. I didn't know if you all even know the curriculum anymore. That's how pathetic it has gotten, they don't even do that anymore. Just that was my other comment. But we train then as new EMTs, how to suction, what all the different devices are and how to use them.
Will Rosenberg: Justin.
Justin Kram: I mean, it seems like there's an opportunity here to improve training across the board because I'd make the argument to that even critical care nurses rely heavily on respiratory to take care of that. So I would imagine that across the board there probably could be more familiarity. As far as the trained person filling a clinical role, I mean, it could be a support role. You know, there's already a caveat for a family member, which is obviously a lay person anyway. And, you know, we're providing some level of medical training and we would expect a non-certified driver to engage in CPR if required or something like that. So it's not like this is a far stretch from what we're doing already, in my opinion. And it would seem reasonable to me that if a layperson family member

who's trained to support the EMT could do it, then why wouldn't someone who's engage in and familiar with the process of interfacility EMS not be similarly trained and relied upon? And of course, if an airway goes sideway, just like anywhere else, you call for additional resources. There are other options. It's not like they are locked into that. My final thought is, whether it's a second EMT or not, they're essentially going to be, if they're not at a facility or at the destination, they're going to be driving anyway, and they're not going to be engaging in a clinical role to begin with, at that moment. So, that was it. Thanks for the opportunity.
Dr. Chizmar: Well, I guess, just a comment on the curriculum. A lot of our programs that are in the state and most of the programs that are teaching EMTs have to teach in one way, shape, or form what the National Registry is going to test or assess. So if it's not in the national scope of practice, the initial programs are likely not going to cover it. And if you look at the national scope of practice for an EMT, they talk about airway adjuncts that go in the oropharynx and nasopharynx. They don't make any mention of inserting airways anywhere else. And I think inherent troubleshooting the airway, I mean, look, this is the airway. If you can't resolve it with suctioning, what's your next step? Your next step is to remove it, try to replace it, and try to manipulate it. And I think calling for additional resources is a great idea, but the question is, what's happening to the patient while you're waiting for 911 to respond to your ambulance on the side of the road? And I know that this is a little bit different because you say, well, in the 911 world, what if they were at home? But they're not at home without any help there. The expectation, I think, of interfacility transport is that the patient is going to go safely from point A to point B. If we were just running them in a private car, there's no expectation that they're going to go safely from point A to point B. The public, I think, expects if they're going in an ambulance that we have selected the right level of care and that they're going to make it from the sending place to the receiving place without having to summon additional resources in most of the cases. That's my take on that. The advantage of interfacility transports is that we know something about the patient, right? We're not going into it like Tyler is when he going to a 911 call and he doesn't know what he's going to get. We know with some reasonable degree of certainty the patient's got an IV, they have a tracheostomy, and they have this and they have that. Sometimes if you don't know, you find out when you get to the ED when you still have help around you and can say, "Wait, this is above my pay grade. I can't take this. I can't take this." You can't do that in the 911 world. When you get there and you realize the patient's bad off then you have to summon additional resources.
Justin Kram: I think you're kind of characterizing what my thought was. We're talking about a very, very small, arguably very small, if almost imperceptible patient population that's going to have some sort of respiratory collapse related to the tracheotomy itself. And in those cases, if a non-certified driver was pressed into, was adequately trained to assist

the EMT, and the EMT managed that airway until those additional resources were there, that would be what would happen anyway. I'm not suggesting that's out default, or I'm just saying that it's a relatively low occurrence issue where you're going to need those additional resources if you get into that situation anyway. If you're going to be replacing the inner cannula on a trach, at that point, you're going to need more help anyway. And in the meantime, I don't see why there a caveat for a family member, but a non-certified driver is a no-go. This doesn't make sense to me.
Will Rosenberg: Well, let me break it down the way that I would understand it. I mean, a trained family member lives with the patient, they're familiar with the equipment, and they take care of the patient, whenever EMS or hospital personnel are not there. I think the methodology, you know, the understanding there is that the caregiver know the equipment, they know the patient, and the non-certified driver, to be very clear, we have no expectation whatsoever that they have any medical knowledge, that they even know what an inner cannula is or knows the equipment.
Justin Kram: They can give directions to the non-certified driver to provide them assistance. You have a trained person that obviously should know how to manage that airway. They're going to be taking primary control of that airway. You're not going to have two people with their hands on the inner cannula and trying to replace it. You're going to have one.
Dr. Chizmar: Look Justin, I'm a realist and I know that people can hand you stuff and do stuff and that people will do stuff. But we're talking about whether the state EMS system is going to sanction people who are unlicensed to participate in medical care. When push comes to shove that non-certified driver has Good Samaritan protection to reply upon. You know, I'm sure, that will work out. Okay for them. But we're not talking about the emergent situation. We're talking about here is how to try to prevent the adverse situation. As you said, high acuity, low frequency. Granted, low frequency, but potentially very high acuity. And we have the advantage of these being scheduled transfers. These are not emergent calls where nobody knows what's going on. That's what we're talking about here. We know ahead of time what we're dealing with and unless Claire or somebody else tells me otherwise, we can't expect or write in the protocol or guidelines or regulations some medical role for non-certified drivers. We just can't do it. We have to certify them as something in order for them to be part of the EMS system.
Claire Pierson: Those regs have gone to the governor's office. But if the idea behind those regs was that those individuals would be providing care that may in any way shape or form look like licensed or certified care, then I think they should come back.
Will Rosenberg: Claire's over here having a stroke Justin, just to give you a heads up. Matt put his hand up at one point in time, but then he also sent through a comment that say basically that EMTs are going to panic in a case of a trach patient and call 911 anyway. It pretty much sums up his

statement. Matt, that's a great point so I guess the question would be why we allow them to go through that process when we know ahead of time that they're going to do that. I'm guessing that Matt's mic doesn't work so we are getting texting. So I'll put my own two cents in here and anyone knows that I am one who really pushes back on MIEMSS. I think they over-regulate, over-legislate, and overstep their bounds on a regular basis. Shame on you, Jimmy, and everybody else from the 80s who was allowed to put two EMTs in the regs because that's where we came into this problem. I do think that it cannot stay with two EMTs. There's no such thing in the protocols. There's not a BLS, but you have got to have two EMTs and stand on your head and spin around. So I agree with Danny, it either has to go to BLS, which is however you make a BLS truck according to the Maryland regs. I agree the family member has to be an option or a pop-off valve, right? Because they know it better than the EMTs are ever going to know. Or it has to go ALS. So, I agree with everybody that EMTs are clueless when it comes to trachs. I do agree with Mike and I think it was Justin that said we can train them and get them there. But I don't think, thanks to MSFA, there's an appetite to have that in the EMT training or the refresher training. And we could say it's incumbent upon the commercial services and we can have trach mannequins to do it. But I am also a realist. Of our 28 commercial services and believing that while there's some great, great services out there, some of the services are not as great as the others and that is not to speak any negative of my colleagues, but I'm a realist and honest with myself. I can even look back at when we started 22 years ago. We could not train a BLS provider to take care of a trach if our lives depended on it. So I'll pick solely on my service, although I think we could easily do it now and I think there's some phenomenal services out there. As long as we have the provider or the family member or home health nurse or home health aide, I think that would provide the option to go BLS, and if you don't, then you are stuck with ALS. That's just Butler Medical's opinion. I'm not any way the sole voice. I think it's important to hear everybody else's and I don't want mine to skew anyone else's opinion. But I don't think you can have two EMTs. It's either got to be BLS, and I'm okay with that, or it's ALS, and I am okay with that as long as you have the family member pop off out. But two EMTs is silly. One EMT that's confused is just as confused as two. Mr. Buchholtz and I know Dr. Chizmar and Claire had something they want to say.

Mark Buchholtz: The protocol was written in a time where two EMTs were BLS, right? So the second EMT was just driving anyway. So what's the difference? I agree with LifeStar that the protocol should just be one. I think the protocol needs to fit the times that we're in now where non-certified driver is part of the BLS makeup.

Dr. Chizmar: Yeah, I guess I would say based on what Matt was saying I think the only difference would have been when the trach problem occurred. That the EMT in the back would panic and the driver would pull

over to the side of the road and get in the back to help, which clearly the non-certified driver, as implied in the name, really is not too helpful to that person and actually taking care of the patient. So, it's a second set of hands. They pull over to the side of the road, instead of calling 911, they manage the thing together, and maybe that alleviates the panic and gets the patient suctioned and on their way to where they need to go. Again, I was not here in the 80's, but that's…
Will Rosenberg: And I jokingly said the 80's. Yes, Jimmy, I know it was the 90's. Claire had something she wanted to add.
Claire Pierson: No, I'm good. I don't think it would be productive.
Dr. Chizmar: But I understand that people wanted to go solo EMT. I think there are enough of you out here, though, that have already acknowledged that EMTs are not adequately trained. And you basically confirm my belief that you don't believe that they're adequately trained. And so we have 15,000 of them that we need to train or do on a continuing education basis. So, while everybody is running around asking if EMTs can do superglottic airways, maybe we can get all 15,000 EMTs in there for a nice 12-hour course on how to manage airways and superglottic airways. We can figure out the fiscal cost item on that one. We can wax philosophical on this. You can keep piling stuff onto the EMT scope If you want to do that, but you're going to have less and less EMTs as time goes on and we're going to run into the same problem we did with CRTs, which is the CRT and the paramedic became almost indistinguishable. I know that this information probably upsets some people in the room and on the call, but we can keep piling stuff on but you have got to realize at some point the two levels are going to become indistinguishable. And, frankly, it's not just the volunteer community. It's everybody that has to pay to train people. Who's going to ride for them in a career?
Will Rosenberg: I was only picking on MSFA because they're the biggest roadblock to moving forward with any kind of training problem. Yes, I am a die-hard volunteer. Just means that the MSFA sits in the 60s.Go ahead Justin.
Justin Kram: Yes, I understand the concern about the training and I understand that there could be room to be done across all licensure levels, but at the end of the day, we're talking about a patient population that is generally very low acuity in general. Most of these patients are being discharged to skilled nursing facilities, or something like that. You know, they're otherwise stable, they just happen to have a trach. That the bulk of the trach patients that we transport. Obviously, there are protocols written for vent-dependent trachs, that sort of thing. But most of these trach-only patients are lower acuity. They're getting discharged. They're relatively easy to manage. This has been within the scope for an EMT, so I have trouble visualizing taking our already limited resources at the ALS level to accommodate what has historically been serviced at the BLS level and to think that there's not going to be unintended consequences there

too that we're not really talking about. That's my other concern. Because we have a finite number of resources and now we're going to shift what little ALS, because we're short EMTs, to these low acuity calls. Where is it really necessary? A good arguments on both sides, but this is a relatively low acuity population.

Will Rosenberg: Just a couple of closing thoughts. How often are we transporting one of these patients where a family member isn't on board, and I think they mean family member, clinician, aid, or what have you. And that was, I think, Jimmy's comment earlier, and that's definitely Matt's comment now. "And speaking as a citizen of Maryland and as an active EMT, I was trained to manage airway when it was less than 130 hours. I can't imagine there isn't enough time in today's EMT courses to effectively teach students to manage an airway. There was a solution in search of a problem." So my question is, what is next? I think everybody agrees that two EMTs is confusing as heck. I think a vast majority would like to see it go BLS, probably greater than 90%, but they would want it to be either EMT and EMT or EMT and EVO, depending on whatever their BLS configuration is, but just BLS. Hopefully I am summarizing your thoughts and do some extra training on the service level, as long as there's a pop-off valve for a third-party clinician. Seems like to be the prominent voice of the committee. So the question is, what is the next steps for MIEMSS?

Dr. Chizmar: I think the next steps obviously would be to take the advice of the committee back internally and to the other groups that should weigh in on this, the educators, and medical directors as well, because I shouldn't be the lone decider here.

Will Rosenberg: So we'll get an update in March.

Dr. Chizmar: The purpose of the advisory committee is to get advice. I'm so advised.

Will Rosenberg: Anything else in your medical director's report? Does anyone have anything for Dr. Chizmar that doesn't involve a tracheostomy? Scott, we've used up all the controversy in the room, so we'll turn it over to your department.

**SOCALR Report**

End of the Year Report – Scott Legore

A little end of the year reporting here, some numbers for you.

| | | |
|---|---|---|
| Renewal Inspections | 70 Inspections | 441 Units |
| New Unit/Transfer Inspections | 60 Inspections | 62 Units |
| SCT Inspections | 11 Inspections | |
| NEO Inspections | 3 Inspections | |
| Base Inspections | 5 Inspections | |
| Site Visits | 7 Visits | |
| New Service Inspections | 5 Inspections | 3 New Services |
| ALS Upgrade Inspections | 3 Inspections | 4 Units |
| VAIP Inspections | 2 Inspections | |

Those are the numbers from this past year. We had to go out five times to Inspect three services, so you can do the math there. Couple of ALS upgrades and then our folks assisted with some VAIP inspections as well. And then random inspections, we did random inspections 147 days last year, visited 985 sites, and inspected a total of 153 trucks.

Inspection/License/Renewal Update – Scott Legore

So the services that have March renewals will be getting their renewal packets during the first week of February. We've already had one service contact us this early, so we're working on getting them out in advance.

QA Review/Data Import – Scott Legore

QA review and Data import, so this is probably the second controversial topic, although we're just going to throw it out right now. We really haven't delved too much into it, other than identifying an issue related to vital signs. So for the last quarter, there were more than 2,200 reports that had either incomplete vital signs or where the clinician stated that the patient refused vital signs. And then for all of 2024, more than 7,500 transports where that was indicated. So we're doing a little bit of a deep dive to try to identify if this is related to specific services or specific clinicians. Scott Barquin worked on a report, so he will probably be reaching out to you. I know he's already reached out to one or two services where this came up as part of a different review. Vital signs are required. If your folks aren't reporting them they are in essence violating the protocol. So we're going to provide that information to you, if you are not already tracking it, and hope to improve the problem. You want to see if there's any comments?
Will Rosenberg: Any comments or concerns on that?
Scott Legore: Scott, do you have anything else on data import before I move one?
Scott Barquin: That pretty much covered it.

Equipment Update - Scott Legore

Nothing new on equipment update. We're going to wait until the protocols are finalized before we see if there are any changes to the equipment update. Again, they'll take place July 1st as usual.

Email Issues – Scott Legore

We have been experiencing some issues with incoming emails being blocked. I want to just throw it out there so everyone understands, at least the best as I can explain it. MIEMSS uses a third party service to scan their incoming emails to determine if they are spam or not. As part of that, this third party service blocks the email and sends it back to the user. When that happens, the email indicates you have been identified as spam. The issue we have is that we do not get notified on our side of the house that the email was blocked. We don't know that we are missing your email. If you get a notification that your email was returned to you

because it's spam, please call into the office or try resending it. Although, if you're blocked once, it may block the email a second time. Please understand that this is going on. Call into the office and we can provide you with alternate email addresses that don't use the same filter. And we are working on some workarounds but the IT department, at least what they reported to me is that the spam filter blocks over 10,000 emails a day, so they're not looking to change. We are having some further internal discussions, but we were hit hard. We had at least six that we know of in the month of December that were blocked from regular users. It's still occurring on a semi-regular basis. We just want to make everybody aware of the problem. If you do get blocked, please give us a call so we can try to work through it.

MIEMSS Personnel Updates – Scott Legore

I have some MIEMSS personnel updates that I would like to make you aware of:
Michelle Bell, from Clinician Services, retired effective January 1st, 2025.
Kathleen Harne has been hired as the ALS Program Coordinator in Clinician Services.
Christian Meely has been hired as the Director of the Office of Government Affairs. He was going to be here in person, but the legislation is in session and he's got a meeting shortly, so he didn't want to have to jump out.
So there will be some new faces in-house around here.

Will Rosenberg: Does anyone have anything for SOCALR? No questions.

**Clinician Services** – Aaron Edwards

We are looking into our reciprocity process to see if we can speed it up a bit. Other than that, not too much to report.

Will Rosenberg: Does anyone have anything for Clinician Services? No questions.

Will Rosenberg: Claire, before we move onto Committee Reports, do you have anything to share?
Claire Pierson: I just want to let you know the Non EMS Driver regulations that were finalized were approved by SEMSAC and the EMS Board. The next step is that they now have to go to the governor's office for approval by a deputy chief of staff before they can be submitted for publication and they're in that phase now. But hopefully with Christian being new, they can move them along because our other set has been with the governor's office for three months. Unrelated to this, but they could be stuck in that phase for a little while.

**Committee Reports**

**SEMSAC** Report – Danny Platt unavailable, Teddy Baldwin advised no report.

**PEMAC** Report – Jill Dannenfelser – No report.

**MIH** Report – Deb Ailiff unavailable, Mark Buchholtz advised no report.

**Old Business** –

EMS Compact – Will Rosenberg

Will Rosenberg: I know Danny addressed this briefly two months ago. Anyone have any comments or something that needs to be discussed on that?

Scott Legore: I think it was just that each individual service was supposed to go back and do some research to see if there was any way they wanted to go, either way. Right now, the discussion, there's no formal movement at the legislature as to forcing us to join the EMS Compact. There was some discussion that there may be some legislation that allows military folks, their level of licensure to be recognized in Maryland, but nothing specific to the EMS Compact. That was the concern that was brought up in the fall as to why this kind of raised up that there would be some moved in the legislature that the EMS compact would be pushed forth as a legislative issue. We're not seeing that right now, but just so you're aware of it. We're keeping everybody in the loop at this point. MIEMSS is not supporting moving into the EMS Compact. I believe there are some issues with the crossing over borders and operating under a different scope of practice and some other issues. So MIEMSS is not supporting it, but we're waiting to see if it's going to rear its head in the legislative process.

Dr. Chizmar: Christian came off mute and then he went back on.

Will Rosenberg: I don't know if he had something to add there from the legislature or?

Christian Miele: No, just wanted to introduce myself to everybody. Thanks for inviting me, Scott, to the meeting today and I am looking forward to representing MIEMSS down at the General Assembly.

Will Rosenberg: Staying on that topic. Welcome Christian. And since he is here, people's thoughts on the EMS Compact. It's good to see it's less lively than tracheostomy patients. Based on the fact no one has anything to say, I'm going to assume no one is that interested in joining the EMS Compact. If I am wrong, now is your time to say that you really think we should join it. I guess CASAC doesn't need to join the EMS Compact. Not that I disagree with us, but just putting it out there. Any new business for the floor?

PureWick – Dr. Chizmar

Dr. Chizmar: Actually, I had an items of old business.
Will Rosenberg: Go ahead.
Dr. Chizmar: So you guys probably remember several moons ago, we talked about the PureWick urinary drainage system. You've see these in the hospitals, you've seen them coming and going. If you have the requisite equipment to transport somebody with a PureWick, I'm more than happy to add that to the table of devices that could go at really any level, at the BLS level.
Will Rosenberg: With one EMT or two?
Dr. Chizmar: It's not as critical as the airway. If the PureWick fails, and it's going to end up all over your unit, that's your problem.
Will Rosenberg: I find that more critical. There's urine all over my unit.
Dr. Chizmar: So as a bit of lighthearted humor, we'll add that into the protocol chart, unless anybody has any concerns or reservations. And honestly, I think you will probably just want to orient your staff with what a PureWick is and the fact that it actually needs to be drawn up to suction so that you don't end up with a wet mess all over your floor when you find out that you didn't hook the PureWick to suction so it wasn't pulling. So, does anybody have any questions about that? It was brought up some time ago and it took a backseat to the TR band, which we settled already.

**New Business** – Will Rosenberg

Will Rosenberg: Any new business? Before Scott rushes to go to For the Good of the Committee. All right, Scott, now it's your turn.

**For the Good of the Committee** – Scott Legore

Scott Legore: Just two items.

Scott Legore: So first there's several education opportunities out there to pass on to your folks. Winterfest, end of the month in Easton, I think January 31st. Mid-Atlantic Transport Conference, February 28th. Miltenberg is coming up March 7th and 8th. And then there is the Medical Director's Symposium, April 9th. A couple of these opportunities don't have the registration or information out yet, but Winterfest and Mid-Atlantic Transport Conference does. If you need that information, just reach out to me. I can forward you that information.

Scott Legore: And then the second items is just a reminder, next month's meeting has been moved to the 25th. It's not the third Wednesday. So, March 25th is out next meeting. That's all I have.

Will Rosenberg: All right. Any other items For the Good of the Committee?

**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, Scott Legore, Donna Geisel, Abby Butler, Claire Pierson, Tyler Stroh, Mustifa Sidik, and Aaron Edwards.

Virtual: Mike Moretti, Justin Kinsey, Mark Buchholtz, Jonathan Siegal, Marty Johnson, Scott Barquin, Rob Weiss, Jimmy Harsh, Steve Rawheiser, Justin Kram, Mary Bell, Bobby Harsh, Jim Pixton, Matt Larrabee, John Pierce, Christian Mieli, Jill Dannenfelser, Leigha McGuin, Teddy Baldwin.

Callers: #1 – Hung up.
#2 – Kevin Barnes
#3 – Anesa Maye
#4 – Hung up.
#5 – Chenelle McQueen