State of Maryland

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State Emergency Medical Services Board
February 11, 2020

Minutes

Board Members Present: Clay Stamp, Chair; Stephen Cox; William J. Frohna, MD (phone); Wayne Tiemersma; James Scheulen, NREMT-P; Sally Showalter, RN; Mary Alice Vanhoy, RN; Dany Westerband, MD.

Board Members Absent: Sherry Adams, RN, Vice-Chair; Dean E. Albert Reece, MD.

Others Present: Dr. Marcozzi; Ms. Landy; Chief Matz;

MSPAC: Capt. Keith McMinn; Major Tagliaferri; Mr. Wood

MIEMSS: Dr. Delbridge; Ms. Gainer; Dr. Chizmar; Ms. Abramson; Ms. Aycock; Ms. Alban; Mr. Bilger; Mr. Brown; Mr. Naumann; Mr. Balthis; Mr. Goff; Ms. Mays; Ms. Gilliam

RACSTC: Tara Carlson, RN

Chairman Stamp called the meeting to order at 9:03 am. He recognized the MIEMSS staff and stakeholders and thanked them for their service.

MIEMSS Report
Dr. Delbridge provided an update to the Board.

EMS Plan – Vision 2030. Dr. Delbridge reported that the EMS Plan Steering Committee had reviewed all the comments on the draft plan that had been received. He said he was reviewing their feedback and modifying the draft as needed.

CRISP. Dr. Delbridge said that statewide integration of eMEDS into CRISP was almost complete, with the addition of Prince George's and Anne Arundel County. Only Cecil County remains to complete their participation agreement.

@HA (Ambulances at Hospitals). This application provides real-time awareness of the EMS – Emergency Department interface by identifying the number of ambulances at emergency departments. Dr. Delbridge said that once completed, EMS personnel would be able to open the App and view the number of ambulances from all jurisdictions at hospitals of interest. MIEMSS is working with jurisdictions to obtain access to their CAD feeds.

CHES. Dr. Delbridge said that emergency department overcrowding continues to be a concern, and MIEMSS is hoping to identify accurate and objective criteria that could be used by all hospitals to identify ED overcrowding.

Dr. Delbridge said that both the @HA and CHES initiatives would assist in more accurate identification of ED overcrowding. Mr. Stamp noted that in the past, EMS was not allowed to provide care to EMS patients waiting in the ED to be off-loaded from the stretcher, but that the practice was more common now. Dr. Delbridge said that EMS should not be starting new therapies on these patients in the ED.

Legislature. Dr. Delbridge reported that MIEMSS' budget hearings had gone well. He said that the legislators were interested in the continuing need for grants to support infectious diseases initiatives; funding for the new models of EMS care including Mobile Integrated Health; and yellow alerts and ED overcrowding.

Designations. Dr. Delbridge reported that White Oak Medical Center received full re-designation as a Primary Stroke Center and Shore Health Queen Anne Emergency Center received full re-designation as a Freestanding Medical Facility.

Rural Health Care. Dr. Delbridge said that MIEMSS met with the Maryland Health Care Commission (MHCC) and the Health Services Cost Review Commission (HSCRC) to discuss models for rural health care. He said that MHCC had conducted a study and were considering several different models, including critical access, freestanding facility that requires a "hub," or an expanded clinic. He said that MIEMSS has stressed that regardless of the model used, an emergency department must be staffed with an ED physician.

SEMSAC Report

Chief Tiemersma reported that the February SEMSAC meeting was cancelled. He said that at the upcoming March meeting, SEMSAC will be discussing EMS sustainability (financial issues, human resources, etc.). He said that Dr. Greg Buehler from Kaiser and Deb Aliff from Procare Ambulance will be discussing their MIH proposal.

MSPAC Report

Capt. McMinn said there was no formal MSPAC report, but noted the recent press coverage on helicopter safety that had followed the helicopter crash involving Kobe Bryant. He said that on March 19th, the MSPAC will celebrate 50 years of Medevac transports.

Chief Tiemersma asked about availability of Trooper 5. Capt. McMinn said that seven (7) pilots are currently being trained and should be released for duty in the March – April timeframe. He said MSPAC would also be getting six (6) medics. He said these additional personnel would assist with increased availability, but 24-hour coverage could not be guaranteed at this point.

MSFA Report

Mr. Cox reported on behalf of the MSFA and said that work on issues in the Legislature was a continuing focus.

RACSTC

No report. Ms. Carlson noted that the Shock Trauma Gala would be held on April 4th.

OLD BUSINESS

Update on BCFD MIH Paramedic / Paramedic Model. Dr. David Marcozzi, Ms. Colleen Landy, and Chief Jim Matz reported on the Baltimore City Fire Department / University of Maryland School of Medicine program. Dr. Marcozzi said the pilot program, approved in August 2019, was initially staffed with a paramedic and a nurse. He said that the utility of this staffing model was limited because availability of nurses was limited, which, in turn, limited the number of patients that could be seen. He said the use of a paramedic – paramedic model will allow the Program to see more patients. He said the paramedic-paramedic model was put into place in the early fall and involved additional training and education and reinstatement of Zoom for all visits. The paramedic-paramedic model was rolled out on October 1st, with the lead paramedic having been approved by double check-offs from direct nursing oversight. He said that different aspects of the model were evaluated from November to January and resulted in several changes, e.g., Zoom is now used for all initial visits and patients triaged as "red." He said that the program had a better understanding of patients' health and social support needs, and there had been zero adverse outcomes and no identified safety incidents or risks. He noted there had been a 29% decrease in ED utilization, a 5% decrease in inpatient admission, and a 26% reduction in observation visits (<23 hr). Those in the program who have been readmitted spend 0.6 fewer days in the hospital.

Ms. Landy said that patients from West Baltimore who are discharged to a home within 6 specified zip codes may be eligible for the program. She said that the program works with the inpatient treatment team for pre-planning. She said that using the new staffing model has allowed the program to work 10 hours / day, which added 1-2 visits / day. She said there were 79 patients in the first cohort and 109 in another. Dr. Marcozzi said that EMS participates in interdisciplinary hospital rounds.

Ms. Landy said that the program received funding from the HSCRC for two years, and funding is sufficient to extend into a third year. She said the funding occurred via a rate adjustment to the hospital that was passed-through to Baltimore City.
Dr. Chizmar noted that the telemedicine component of the program was important, as was the additional training provided to paramedics (40+ hours).

Regulations. Ms. Sette presented the following regulations:

- Adult & Pediatric Burn Center Standards. Ms. Sette said the Board had previously approved these standards for publication in the Maryland Register. She said that no comments had been received on the standards.

Upon the motion of Ms. Showalter, which was seconded by Mr. Scheulen, the Board unanimously approved the Adult & Pediatric Burn Center Standards.

- Perinatal & Neonatal Referral Center Standards. Ms. Sette presented these standards for information and said the standards are updated every five (5) years. She said that the Maryland Department of Health has a Perinatal Advisory Committee that updates the standards, which are then translated into MIEMSS COMAR regulations and used for designation purposes. She said there were several notable changes, including educational standards for hospitals, a new requirement for a dietician for Level IV centers, and the ability to care for obese patients. She said the Board would vote on the standards at an upcoming meeting.

Conversion of UM Harford Memorial Hospital to a Freestanding Medical Facility (FMF). Ms. Sette reminded the Board that the MHCC may exempt a hospital-to-freestanding conversion from Certificate of Need requirements depending on certain factors, one of which is whether the conversion will maintain adequate and appropriate delivery of emergency care within the statewide emergency medical services

system, as determined by the State Emergency Medical Services Board. The Board previously determined that the Harford Memorial conversion would maintain appropriate delivery of emergency care. Since that determination, the conversion project had been revised, but none of the revisions would alter the Board's initial determination.

Mr. Scheulen said these conversions result in changes to EMS and changes in patient transfer patterns that result in transfers to additional facilities; he said any reduction in hospital capacity affects EMS. Chief Tiemersma said that hospitals have indicated that conversion is preferable to hospital closure. Chairman Stamp asked if the Board had sufficient ability to have meaningful input to these conversions. Ms. Sette said that MIEMSS will be drafting changes to COMAR regulations to account for subsequent modifications in conversion plans. Dr. Delbridge said that we need to think more carefully about the impact of these changes on the health care system and health care market. He also said that we do not have the ability to create transportation systems that impacts patient flow. Ms. Vanhoy said that we should communicate to the MHCC the Board's concerns about adequate hospital capacity for emergency care.

Cardiac Monitors. Chief Tiemersma said that funding for cardiac monitors has been an issued discussed at SEMSAC and the Board. Mr. Naumann presented information on the MIEMSS Cardiac Monitor Grant program. He said that grant program was established to fund 50% of costs of cardiac monitors in cases where companies needed financial assistance to purchase the devices. MIEMSS has provided $400,000/year in funding for this purpose between 1997 and 2019; funding was increased to $425,000 in 2020. He said that MIEMSS has worked to ensure that grant requirements and processes are clear and consistent. He said all applications for funding were fully funded in this current year, although a few had been received after the application deadline. He said that jurisdictions should spend grant monies by March 6th in order to be eligible for reimbursement. Unused monies will be reallocated to other grant recipients.

Mr. Naumann said that CARES data shows that less than half of those with cardiac arrests in Maryland receive bystander CPR; less than 10% have AEDs applied by bystanders; and Maryland's overall survival rate is worse than the national average.

Chair Stamp said there were three options to consider: 1) maintain grant funding at the current level; 2) modify the grant funding amount; or 3) use grant money for other purposes. He said that it is important to ensure funds are used in the most effective way.

Ms. Vanhoy said that the cardiac monitor grant program was originally established as a hardship grant when EMS was provided largely through volunteers, not by county and local governments. She said that it appears at present that nearly half the funding goes to these government systems, which is not consistent with the original purpose of the grant. She asked what the State's responsibility to provide financial assistance to these municipal systems.

Chief Tiemersma expressed frustration with jurisdictions that were awarded funding, but did not use the funds. He noted that some counties need assistance more than others do. Mr. Cox said that some departments do not apply because they believe that will not be awarded funds. He believes there is not enough money available in the Program for needed purchases, particularly for rural areas. Chief Tiemersma also said that Lucas devices had been permitted in previous years, but were not in the current year.

Mr. Naumann said that the grant funds could be used to address critical needs, and permitted uses of grant funds could change depending on needs. Chairman Stamp said this could involve input by the

Regional Councils and SEMSAC to identify target opportunities, to measure progress and determine if goals were met. Chief Tiemersma said that counties need to improve planning so they can appropriately use the grant funds, because the grant requires a 50% match.

Chair Stamp asked the Board for their thoughts on options. Dr. Delbridge said that when the grant started, there was a specific, identified need. He said that the Program appears to be in maintenance mode. He suggested that the Board also consider re-purposing the grant to address current needs, e.g., increasing use of CPR and AEDs; recruiting EMS personnel for rural areas. This could be accomplished through a workgroup representing stakeholders that would identify system wide needs and figure out how to use limited resources strategically to meet needs.

Chief Tiemersma said he favors MIEMSS submitting a supplemental budget request for additional funds. Chair Stamp said that MIEMSS must be able to substantiate any request for additional funds, and he is concerned that a justification for increasing the budget has not been developed. Ms. Abramson said that the budget process allows the agency to request only one over-the-target budget item that must be based on legislation or other significant rationale.

Upon the motion of Mr. Scheulen, which was seconded by Ms. Vanhoy, the Board voted to maintain the current funding level of the Cardiac Grant Program; and to charge MIEMSS and SEMSAC with reviewing the focus / purpose of the Program and considering how funds could best be used and reporting to the Board in July 2020.

NEW BUSINESS

Protocols. Dr. Chizmar presented for approval the following protocol changes:

- Needle Decompression for Children < 15. Dr. Chizmar said that the protocol change splits-out treatment for children under age 15. He said the change is based on ATLS guidance and input from Hopkins and Children's Hospital in DC. He said that EMS treats only a small number of these children every year, e.g., approximately 13/year.

Upon a motion by Ms. Vanhoy, which was seconded by Mr. Cox, the Board approved the change in needle decompression for children under age 15.

- Direct-to-Triage Pilot Protocols (Montgomery County and Anne Arundel County). Dr. Chizmar explained that door-to-triage protocols permit EMS to transport low-acuity patients to a hospital ED, take the patient to the triage area and then return to service. He said the two counties differ slightly in the approach to implementation, which will help evaluate the effectiveness of different approaches. He said that the Montgomery County pilot protocol includes discussion with the triage nurse. He said that both jurisdictions have discussed their approaches with hospitals in their service area and the hospitals have agreed to the protocol procedures to be used.

Upon a motion by Chief Tiemersma, which was seconded by Mr. Scheulen, the Board approved both the Montgomery County and Anne Arundel County Direct-to-Triage Protocols.

There being no further business for the Open Session, the Board adjourned to Closed Session by acclamation.