

**REGION I EMS ADVISORY COUNCIL MEETING**  
**JANUARY 19, 2017**  
**Agenda**

- I.** Call to Order
- II.** Approval of Oct. 20, 2016 Minutes
- III.** Welcome Guests
- IV.** Chairperson's Report
- V.** Committee Reports
  - a.** Prehospital Care System
  - b.** Quality Improvement
  - c.** Bylaws/Membership
  - d.** ALS Advisory Committee / Garrett College
  - e.** Region I Emergency Services Education Council Inc.
- VI.** Garrett County Activities
  - a.** Garrett Regional Medical Center – Jeff Hinebaugh
  - b.** Garrett County Emergency Management / ESB - John Frank
  - c.** Garrett County Communications – Ken Collins
  - d.** Garrett County EMS – Wayne Tiemersma
  - e.** Garrett County Health Department - Diane Lee
- VII.** Allegany County Activities
  - a.** Allegany County Emergency Management / Communications – Dick DeVore
  - b.** Allegany County Emergency Services Board – Ken May
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  - d.** Allegany County Health Department – Alison Robinson
  - e.** Western Maryland Health System – William Hardy
  - f.** Allegany College of Maryland – Kathy Condor
- VIII.** Regional Reports
  - a.** Regional Medical Director – Dr. William May
  - b.** Region I Specialty Center – Elizabeth Wooster
  - c.** MFRI – Todd Dyche
  - d.** MEMA - John Reginaldi
  - e.** Medevac – Alex Kelly
  - f.** CISM – Al Ward
  - g.** AGCVFRA
  - h.** Region I & II Health Care Coalition
  - i.** Career Fire & EMS – Donnie Dunn
  - j.** Commercial Ambulance – Chris Guynn
- IX.** MIEMSS
  - a.** Region I Report – Dwayne Kitis
- X.** Old Business
- XI.** New Business
  - a.** Appointment to Board of Directors for FAAS
  - b.** SEMSAC positions available
- XII.** Adjournment

# Region I EMS Advisory Council Meeting

*January 19, 2017*

The Region I EMS Advisory Council Meeting was held January 19, at 7:00 p.m. in the upstairs meeting room at Frostburg Area Ambulance Service. Members in attendance included: Elizabeth Wooster, Bill Hardy, Dr. William May, Ken May, John Frank, Donnie Dunn, Robert Pattison, Wayne Tiemersma, Chris Guynn, Diane Lee, Doug Beitzel, Kathy Condor, Alex Kelly, Al Ward, Cheryl Rexrode, and Dwayne Kitis.

The meeting was called to order by Wayne Tiemersma at 7:00 p.m.

## Approval of October 20, 2016 Minutes:

The minutes were reviewed and accepted as written.

## ***Welcome Guests***

Guest attending included: Mark New (MIEMSS L&C) and Jim Koon (FAAS)

- Mark New reviewed and answered any questions on the new Licensure system. He said that it can process people faster as long as they are in the system; every provider needs to create an account and have an active and correct email in the system. You can view your current CEUs as well as archived training; some lingo/terms have changed also. If anyone has questions or problems with the system, they should call or put in a ticket for help/support.
- Jim Koon updated the group on the situation at Frostburg Area Ambulance Services. They would like someone to be appointed to the Board of Directors from the Council – Bill Hardy volunteered

***Chairperson's Report*** – No report

## ***Committee Reports***

Prehospital Care System – No report

Quality Improvement – No report

## Bylaws/Membership

- The new membership list (please see attachment) was reviewed and passed.

ALS Advisory Committee / Garrett College – Doug Beitzel

- Doug gave an update on ALS training in the Region, please see attachment. He also presented a handout on the ALS Budget Request for the coming year, which was voted on and approved by the Committee.
- Wayne congratulated the College on receiving zero citations during their re-accreditation process from the Committee of Accreditation of Educational Programs for Emergency Medical Services Professions (CoAEMSP). They are one of the few paramedic programs in the nation to receive no citations.

Region I Emergency Services Education Council, Inc. – Dwayne Kitis

- Preparation for the Miltenberger Seminar is in full swing now. The brochure was sent out recently and we are already receiving some registrations.
- The Night for Stars program is in need of funding for this year.

## ***Garrett County Activities***

Garrett Regional Medical Center – No report

Garrett County Emergency Management / ESB – John Frank

- John said he is very pleased with the ESB on the work they have been doing dealing with the fragile situation with ambulances in Garrett County. County staff went from 7 to 31 employees.
- They are moving forward with the Emergency Operations Center Project which was just adopted and approved by the County Commissioners. The conceptual design should be done within 45 days and they hope to break ground in March.
- The LEPC is busy with an active shooter program and an emergency operations plan for Garrett County. They are planning for a late spring tabletop and then a full drill in late summer or early fall.
- They are developing a regional Incident Management Team within Emergency Management and are doing training now.

Garrett County Communications – John Frank

- A meeting will be held on the 23<sup>rd</sup> in Garrett County for WAGIN – Washington, Allegany, Garrett Interoperability Network committee. They will be discussing the future of the committee.
- Garrett County has received money for 15 mobile and 12 portable radios for the new radio system

Garrett County EMS – Wayne Tiemersma

- Garrett County EMS did hire more people and may hire a few more soon. They are trying to maintain a County Chase Car in service.
- They have received a grant for ballistic gear to be placed on EMS vehicles in the county.
- Also have 16 Go Kits with ALS gear in them which can be carried in personal vehicles of County staff.
- The Lifepak15 that was requested through the 50/50 Grant has been received.

Wayne also updated the committee on Regional Affairs and SEMSAC: Guidance should be coming out in the next 60 days or so for Homeland Security funds. It sounds like the goal this year will be active assailant again and they would like us to do more ICS position specific training.

He reported on points of interest from the BLS Committee meeting, too: 1) Changes in reciprocity for BLS providers – as of now they still need to do skills check off and protocol review; there will be specified persons to help walk them through this process. 2) There are still some issues with the Licensure portal. 3) The issue with SIPs (Students in Process) is being addressed – MFRI is doing group testing now instead of after each module and they have changed the course to match the National Registry. In our area, EMT passing rates are above national rates. 4) Taking EMR to EMT Bridge is being looked at by the group.

Garrett County Health Department – Diane Lee

- In November the Health Department received national accreditation from the Public Health Accreditation Board. They were 1 of only 6 local health departments in the state to be accredited and 1 of 200 in the nation.
- The HD is now creating a Health Improvement Plan
- There is a Health Planning website – [GarrettPlan.org](http://GarrettPlan.org); anyone can go on and post to it for questions /answers; a new person has been hired to deal with social media and the website.

***Allegany County Activities***

Allegany County Emergency Management and Communications – Robert Pattison

- At their last public meeting of 2016 the County Commissioners approved the funding necessary for the new radios in the county; it went to bond for that project.
- All radios are in now and installation will start in the spring; pagers will also be included for each department.

Allegany County Emergency Services Board – Ken May

- Companies are experiencing financial problems because of the number of calls they receive that are not transports and not billable. He gave examples of 6-month stats for two companies – one company ran 543 calls with only 125 being transports; another company ran 384 calls and of those 154 were transports.
- Ken also mentioned that he has stepped down after 36 years as president of LaVale Rescue Squad; new president is Ray Shipley.

Allegany County EMS – Robert Pattison

- If Rocky Gap continues to perform, it is projected that \$26,000 in additional funds will be available for each department this year; an increase of almost \$15,000.
- John Hearth officially retired on January 3, 2017; his last day of work was December 19.
- The County hired Paramedic Chris Sullivan; his start date is Feb 1, 2017
- Today the Community Paramedicine Project was presented to the County Commissions at their meeting. It was well received and will be moving forward in the county

Allegany County Health Department – No report

WMHS

- WMHS will start a clinical affiliation with UPMC.
- Community Paramedicine Program will be moving forward.
- They are working on a grant for converting another part of the hospital to an ED if they should lose the use of the existing ED; project should be completed by August.

- The Director of Safety & Security will be leaving on the 27<sup>th</sup> with no replacement yet. His responsibilities have been split up for now. Emergency Management area will be Bill Hardy's responsibility for now.

Allegany College of Maryland – Kathy Condor

- AHEC West is having a Nursing Conference at the hospital on April 7, 2017.
- The CISM training in November went well.

***Regional Reports***

Regional Medical Director

Dr. May will be leaving the area sometime in April and moving to Georgia. His last day at the hospital will be near the end of March. Everyone expressed their thanks to him for serving as our Region I Medical Director and for all that he has done in the area for so many years. It has been an honor and privilege to work with him.

Region I Specialty Center – Elizabeth Wooster

- The Trauma Center re-designation process occurs again in 2018; there will be significant changes to COMAR by then.
- Classes have been held in Garrett and Allegany counties on Bleeding Control; courses have gone well and hands-on stations, too. The course runs about two and a half hours with 30 people or less in the class. We will be having a class at the Miltenberger Seminar also. Garrett County also plans to teach to specific groups in the schools.
- The National Academy of Sciences Health and Medicine Division published recommendations for a National Trauma Care System; talks about taking the way things are done in military and civilian medicine and combining them together for a better system of care. A handout was provided, please see attachment.

MFRI

- A handout was provided on EMS classes in the Region. Please see attachment. It was noted that the Southern EMT class was cancelled since only 6 people had registered.

MEMA

- John Reginaldi sent an information handout to be provided to the membership. (See attachment)

Medevac – Alex Kelly

- They are doing active recruitment for flight paramedics; recruiting at conferences and other areas.
- Also getting ready to bring a flight simulator from Italy here to train our pilots instead of having to send them somewhere else for training.

CISM – Al Ward

- CISM training class was held in November with 34 attending; of those attending 25 were from Western Maryland and they received 5 applications out of those.
- Teams are available to do training for Departments, too

AGCVFRA

- \$10,000 has been raised for EMS/Fire Line of Duty Death Memorials for each county. Garrett County's memorial will be placed at the Visitors Center in McHenry and Allegany's will be on Kelly Road.
- MSFA will be looking at cancer in firefighters.

Region I & II Healthcare Coalition

- Looking at projects for next year's money. If you have a project or are aware of a need of one for Med Surge in the area, please let them know. The project has to be medically related.

Career Fire & EMS – Donnie Dunn

- The City averaged 6 ambulance calls a day and 3.5 other calls a day for 2016.
- They lost 10 people in the last year and a half with some being to retirement - no replacements yet; putting a strain on their people. The County is trying to put plans in place to help take some of the burden off of the City for the calls they make in the county out of the City area.

Commercial Ambulance – Chris Gynn

- There have been a lot of personnel changes in MIEMSS Commercial Licensing.
- Valley Medical Transport has moved their base of operations in Cumberland to East Roberts Street.
- He thanked Dr. May, Elizabeth Wooster and Doug Beitzel for all the help and work they each have done for Valley Medical.

MIEMSS Region I Report – Dwayne Kitis

- Base Station site surveys are now the MIEMSS Regional Administrators responsibility; applications will also be sent to the Regional Offices.
- Dr. Alcorta appointed Dr. Stephanie Sisler as our Pediatric Medical Director; she still has to sign the contract.

***Old Business***

- Wayne reported that there will be some minor changes to the Region I Alert System. Drills were performed a few weeks ago at both facilities; they went well and a report will be pushed out soon on lessons learned, etc.

***New Business***

The Council received a letter from SEMSAC concerning a Volunteer Provider position on their committee. SEMSAC has requested that each Regional EMS Council submit 3 candidates for the Board's consideration to fill that position.

After discussion, Robert Pattison and Al Ward volunteered.

***Adjournment***

The meeting adjourned at 8:40 p.m.

**Region I EMS Advisory Council Membership  
January 19, 2017**

<b>Member</b>	<b>Representation</b>		<b>Expiration Date</b>
Elizabeth Wooster	Region 1 Specialty Center	No Action Required	01/15/19
Jill Spiker	Emergency Department Manager - Allegany County	No Action Required	01/15/19
Jeffrey Hinebaugh	Emergency Department Manager - Garrett County	No Action Required	01/15/19
<b>Dr. William May</b>	Regional Medical Director	<b>Reappointment</b>	<b>01/19/20</b>
VACANT	Regional Pediatric Medical Director	VACANT	
Kenneth May	Allegany County Emergency Services Board	No Action Required	01/15/19
John Frank	Garrett County Emergency Services Board	No Action Required	01/15/18
Donna Struntz	Allegany-Garrett Counties Vol. Fire & Rescue Association	No Action Required	01/15/19
Donnie Dunn	Career Fire & EMS Departments	No Action Required	01/15/19
Richard DeVore	Allegany County Department of Public Safety - Emergency Mgt & Communications	No Action Required	01/15/19
<b>Robert Pattison</b>	Allegany County Department of Public Safety - EMS Division	<b>Appointment</b>	<b>01/15/19</b>
<b>Ken Collins</b>	Garrett County Emergency Management & Communications	<b>Reappointment</b>	<b>01/19/20</b>
<b>Wayne Tiemersma</b>	Garrett County Emergency Management - EMS	<b>Reappointment</b>	<b>01/19/20</b>
<b>Chris Guynn</b>	Commercial Ambulance	<b>Reappointment</b>	<b>01/19/20</b>
Alison Robinson	Health Department – Allegany County	No Action Required	01/15/19
Diane Lee	Health Department – Garrett County	No Action Required	01/15/19
<b>Doug Beitzel</b>	Education – Garrett County	<b>Reappointment</b>	<b>01/19/20</b>
Kathy Condor	Education – Allegany County	No Action Required	01/15/19
Todd Dyche	MFRI	No Action Required	01/15/19
<b>Alex Kelly</b>	MSP Aviation Division	<b>Reappointment</b>	<b>01/19/20</b>
Allan Ward	MCISM	No Action Required	01/15/18
Don Malaney	Public At Large – Allegany County	No Action Required	01/15/19
Cheryl Rexrode	Public At Large - Garrett County	No Action Required	01/15/19

# Garrett College – ALS Training report for Region 1 EMS Advisory Meeting

January 19, 2017 - 1900 hours  
Frostburg Area Ambulance Service

## **2014-2016 Paramedic class**

Of the 22 students who completed course; currently 10 are Maryland Paramedic, 4 are NRP's and testing for Maryland Paramedic and 8 are in the process for testing at the national level. Also during this cohort, after the first year: 17 students became CRT's, and 1 became a West Virginia EMTI.

## **2016-2018 Paramedic class**

34 applications were received. 26 students were accepted and started the fall paramedic course on September 1st. The first semester ended on Dec. 19<sup>th</sup>. 23 students completed the first semester, passing all classroom and completing all clinical requirements. 3 students had to retest the final (all passed) and are currently completing their clinical requirements.

## **Accreditation**

Our re-accreditation process finished with a site visit on Dec. 8 & 9, 2016. A team from CoAEMSP (Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions) was on campus for two days. They met with the Dean and staff of the paramedic program. They interview past and current students as well as the advisory board. They visited clinical and field sites and reviewed all workings of the program itself and reviewed student files. We are happy to report; we are one of the few paramedic programs in the national receiving zero citations or progress reports for the next 5 years. This still has to be confirmed at their next board meeting in March prior to us receiving official notice.

## **New Allied Health classroom and Simulation Labs**

An open house and dedication program was held for the new allied health classroom and simulation labs on Monday, January 9, 2017. It was well attended by the Garrett County Commissioners, Appalachian Regional Commission, Senator Mikulski/Van Hollen's office, Senator Cardin's office, MIEMSS, Tri County Council, Garrett Regional Medical Center and Acting President Al Coviello and administrative staff of Garrett College, EMS chiefs, instructors and students. We are happy to have this area in full operation as it will continue to assist us in educating EMS providers.

## **Advance Medical Life Support (AMLS) class**

An AMLS class will be held at the CTTC on Feb 25 & 26. Providers may register at [www.mfri.org](http://www.mfri.org). Deadline for registration is Feb 5.

## **Regional 1 ALS Skills Evaluation**

Region 1 ALS skills evaluations are currently being done at locations in both Allegany and Garrett counties for those providers who expire in 2017.

## **FY'18 Budget**

We are presenting the Garrett College Emergency Services Training Center FY'18 budget request for approval. (See separate sheet)

GARRETT COLLEGE  
EMERGENCY SERVICES TRAINING CENTER FY'18  
BUDGET REQUEST

**REVENUE**

**1. MIEMSS FUNDING**

PARAMEDIC	\$20,000.00	
ITLS	\$1,500.00	
PALS	\$1,500.00	
MISCELLANEOUS CE	\$6,000.00	
TOTAL MIEMSS	<u>\$29,000.00</u>	\$29,000.00

**2. COUNTY COMMISSIONERS**

<u>\$17,500.00</u>	\$17,500.00
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**3. STUDENT TUITION & FEES**

PARAMEDIC (\$400 x 30 )	\$13,500.00
ITLS (\$160 x 20)	\$3,200.00
PALS (\$150 x 30)	\$4,500.00

**4. REGION 1 ALS SKILLS**

50 providers x \$75)	\$3,750.00	
TOTAL TUITION/FEES	<u>\$24,950.00</u>	\$24,950.00

<b>TOTAL REVENUE</b>	<u>\$71,450.00</u>	<u>\$71,450.00</u>
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**EXPENSES**

**1. PAYMENT FOR INSTRUCTION (Includes fringe @ 8.5%)**

PARAMEDIC	\$24,572.00	
ITLS	\$1,700.00	
PALS	\$2,000.00	
TOTAL INSTRUCTION	<u>\$28,272.00</u>	\$28,272.00

**2. PAYMENT FOR PRACTICAL EVALUATIONS (Includes fringe @ 8.5%)**

NATIONAL REGISTRY	\$2,250.00	
TOTAL PRACTICAL EVALUATIONS	<u>\$2,250.00</u>	\$2,250.00

**3. PROGRAM ADMINISTRATION**

PROGRAM DIRECTOR	\$10,750.00	
PROGRAM COORDINATOR	\$8,000.00	
TOTAL PROGRAM ADMINISTRATION	<u>\$18,750.00</u>	\$18,750.00

**4. SUPPLIES/TEXTS/CERTIFICATION FEES**

SUPPLIES	\$5,568.00	
PARAMEDIC STUDENT TEXTS (\$130 x 30)	\$3,900.00	
FISDAP STUDENT ACCOUNTS (\$100 X30)	\$3,000.00	
ITLS TEXTS (\$70 X 20)	\$1,400.00	
PALS TEXTS (\$55 x 30)	\$1,960.00	
ITLS CERTIFICATION FEES (\$25 X 20)	\$500.00	
PALS CERTIFICATION FEES (\$10 X 30)	\$300.00	
CADAVERS	\$1,200.00	
REGION 1 ALS SKILLS (\$420 x 5 classes)	\$2,100.00	
Accreditation - CoAEMSP	\$1,700.00	
Accreditation - CAAHEP	\$550.00	
TOTAL	<u>\$22,178.00</u>	\$34,850.00

<b>TOTAL EXPENSES</b>	<u>\$71,450.00</u>	<u>\$71,450.00</u>
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# RECOMMENDATIONS

Health and Medicine Division

JUNE 2016 • A NATIONAL TRAUMA CARE SYSTEM

## RECOMMENDATION 1

**The White House should set a national aim of achieving zero preventable deaths after injury and minimizing trauma-related disability.**

## RECOMMENDATION 2

**The White House should lead the integration of military and civilian trauma care to establish a national trauma care system. This initiative would include assigning a locus of accountability and responsibility that would ensure the development of common best practices, data standards, research, and workflow across the continuum of trauma care.**

To achieve the national aim (Recommendation 1), the White House should take responsibility for

- creating a national trauma system comprising all characteristics of a learning organization as described by the Institute of Medicine;
- convening federal agencies (including HHS, DOT, VA, DHS, and

DoD) and other governmental, academic, and private-sector stakeholders to agree on the aims, design, and governance of a national trauma care system capable of continuous learning and improvement;

- establishing accountability for the system;
- ensuring appropriate funding to develop and support the system;
- ensuring the development of a data-driven research agenda and its execution;
- ensuring the reduction of regulatory and legal barriers to system implementation and success;
- ensuring that the system is capable of responding domestically to any (intentional or unintentional) mass casualty incident; and
- strategically communicating the value of a national trauma care system.

## RECOMMENDATION 3

**The Secretary of Defense should ensure combatant commanders and the Defense Health Agency (DHA) Director are responsible and held accountable for the integrity and quality of the execution of the trauma care system in support of the aim of zero preventable deaths after injury and minimizing disability. To this end**

- **The Secretary of Defense also should ensure the DHA Director has the responsibility and authority and is held accountable for defining the capabilities necessary to meet the requirements specified by the combatant commanders with regard to expert combat casualty care personnel and system support infrastructure.**
- **The Secretary of Defense should hold the Secretaries of the military departments accountable for fully supporting DHA in that mission.**
- **The Secretary of Defense should direct the DHA Director to expand and stabilize long-term support for the Joint Trauma System so its functionality can be improved and utilized across all combatant commands, giving actors in the system access to timely evidence, data, educational opportunities, research, and performance improvement activities.**

To meet the needs of the combatant commanders, the accountable DHA leader should sustain and fund elements of a learning trauma care system that are performing well within DoD, and better align efforts that today are fragmented or insufficiently supported. Steps to take to these ends include

- developing policies to support and foster effective engagement in the national learning trauma care system;
- integrating existing elements of a learning system into a national trauma care system;
- maintaining and monitoring trauma care readiness for combat and, when needed, for domestic response to mass casualty incidents;
- continuously surveying, adopting, improving and, as needed, creating novel best trauma care practices, and ensuring their consistent implementation across combatant commands;
- supporting systems-based and patient-centered trauma care research;
- ensuring integration across DoD and, where appropriate, with the VA, for joint approaches to trauma care and development of a unified learning trauma care system;
- arranging for the development of performance metrics for trauma care, including metrics for variation in care, patient engagement/satisfaction, preventable deaths, morbidity, and mortality; and
- demonstrating the effectiveness of the learning trauma care system by each year diffusing across the entire system one or two deeply evidence-based interventions (such as tourniquets) known to improve the quality of trauma care.

#### RECOMMENDATION 4

**The Secretary of Health and Human Services (HHS) should designate and fully support a locus of responsibility and authority within HHS for leading a sustained effort to achieve the national aim of zero preventable deaths after injury and minimizing disability. This leadership role should include coordination with governmental (federal, state, and local), academic, and private-sector partners and should address care from the point of injury to rehabilitation and post-acute care.**

The designated locus of responsibility and authority within HHS should be empowered and held accountable for

- convening a consortium of federal (including HHS, DOT, VA, DHS, and DoD) and other governmental, academic, and private-sector stakeholders, including trauma patient representatives (survivors and family members), to jointly define a framework for the recommended national trauma care system, including the designation of stakeholder roles and responsibilities, authorities, and accountabilities;
- developing a national approach to improving care for trauma patients, to include standards of care and competencies for pre-hospital and hospital-based care;

#### RECOMMENDATION 5

**The Secretary of Health and Human Services and the Secretary of Defense, together with their governmental, private, and academic partners, should work jointly to ensure that military and civilian trauma systems collect and share common data spanning the entire continuum of care. Within that integrated data network, measures related to prevention, mortality, disability, mental health, patient experience, and other intermediate and final clinical and cost outcomes should be made readily accessible and useful to all relevant providers and agencies.**

To implement this recommendation, the following specific actions should be taken:

- Congress and the White House should hold DoD and the VA accountable for enabling the linking of patient data stored in their respective systems, providing a full longitudinal view of trauma care delivery and related outcomes for each patient.
- The Office of the National Coordinator for Health Information Technology should work to improve the integration of prehospital and in-hospital trauma care data into electronic health records for

#### RECOMMENDATION 6

**To support the development, continuous refinement, and dissemination of best practices, the designated leaders of the recommended national trauma care system should establish processes for real-time access to patient-level data from across the continuum of care and just-in-time access to high-quality knowledge for trauma care teams and those who support them.**

The following specific actions should be taken to implement this recommendation:

- DoD and HHS should prioritize the development and support of programs that provide health service support and trauma care teams with ready access to practical, expert knowledge (i.e., tacit knowledge) on best trauma care practices, benchmarking effective programs from within and outside of the medical field and applying multiple educational approaches and technologies (e.g., telemedicine).
- Military and civilian trauma management information systems should be designed, first and foremost, for the purpose of improving the real-time front-line delivery of care. These systems should follow the principles of bottom-up design, built around

- ensuring that trauma care is included in health care delivery reform efforts;
- developing policies and incentives, defining and addressing gaps, resourcing solutions, and creating regulatory and information technology frameworks as necessary to support a national trauma care system of systems committed to continuous learning and improvement;
- developing and implementing guidelines for establishment of the appropriate number, level, and location of trauma care centers within a region based on the needs of the population;
- improving and maintaining trauma care readiness for any (intentional or unintentional) mass casualty incident, using associated readiness metrics;
- ensuring appropriate levels of systems-based and patient-centered trauma care research;
- developing trauma care outcome metrics, including metrics for variation in care, patient engagement/satisfaction, preventable deaths, morbidity, and mortality; and
- demonstrating the effectiveness of the learning trauma care system by each year diffusing across the entire system one or two deeply evidence-based interventions (such as tourniquets) known to improve the quality of trauma care.

all patient populations, including children.

- The American College of Surgeons, the National Highway Traffic Safety Administration, and the National Association of State EMS Officials should work jointly to enable patient-level linkages across the National EMS Information System project's National EMS Database and the National Trauma Data Bank.
- Existing trauma registries should develop mechanisms for incorporating long-term outcomes (e.g., patient-centered functional outcomes, mortality data at 1 year, cost data).
- Efforts should be made to link existing rehabilitation data maintained by such systems as the Uniform Data System for Medical Rehabilitation to trauma registry data.
- HHS, DoD, and their professional society partners should jointly engage the National Quality Forum in the development of measures of the overall quality of trauma care. These measures should include those that reflect process, structure, outcomes, access, and patient experience across the continuum of trauma care, from the point of injury, to emergency and in-patient care, to rehabilitation. These measures should be used in trauma quality improvement programs, including the American College of Surgeons Trauma Quality Improvement Program (TQIP).

key clinical processes and supporting actors at all levels through clinical transparency, performance tracking, and systematic improvement within a learning trauma care system. Therefore, the greater trauma community, with representation from all clinical and allied disciplines, as well as electronic medical record and trauma registry vendors, should, through a consensus process, lead the development of a bottom-up data system design around focused processes for trauma care.

- HHS and DoD should work jointly to ensure the development, review, curation, maintenance, and validation of evidence-based guidelines for prehospital, hospital, and rehabilitation trauma care through existing processes and professional organizations.
- Military and civilian trauma system leaders should employ a multipronged approach to ensure the adoption of guidelines and best practices by trauma care providers. This approach should encompass clinical decision support tools, performance improvement programs, mandatory pre-deployment training, and continuing education. Information from guidelines should be included in national certification testing at all levels (e.g., administrators, physicians, nurses, physician assistants, technicians, emergency medical services).

#### RECOMMENDATION 7

**To strengthen trauma research and ensure that the resources available for this research are commensurate with the importance of injury and the potential for improvement in patient outcomes, the White House should issue an executive order mandating the establishment of a National Trauma Research Action Plan requiring a resourced, coordinated, joint approach to trauma care research across the U.S. Department of Defense, the U.S. Department of Health and Human Services (National Institutes of Health, Agency for Healthcare Research and Quality, Centers for Disease Control and Prevention, U.S. Food and Drug Administration, Patient-Centered Outcomes Research Institute), the U.S. Department of Transportation, the U.S. Department of Veterans Affairs, and others (academic institutions, professional societies, foundations).**

This National Trauma Research Action Plan should build upon experience with the successful model of the NRAP and should

- direct the performance of a gap analysis in the military and civilian sectors that builds on previous analyses, looking at both treatment (clinical outcome studies) and systems research to identify gaps across the full continuum of care (prehospital and hospital-based care and rehabilitation) and considering needs specific to mass casualty incidents (e.g., natural disasters, terrorist attacks) and special patient populations (e.g., pediatric and geriatric patient populations);
- develop the appropriate requirements-driven and patient-centered research strategy and priorities for addressing the gaps with input from armed forces service members and civilian trauma patients;
- specify an integrated military-civilian strategy with short, intermediate and long-term steps for ensuring that appropriate military and civilian resources are directed toward efforts to fill the identified gaps (particularly during interwar periods), designating federal and industry stakeholder responsibilities and milestones for implementing this strategy; and
- promote military-civilian research partnerships to ensure that knowledge is transferred to and from the military and that lessons learned from combat can be refined during interwar periods.

#### RECOMMENDATION 8

**To accelerate progress toward the aim of zero preventable deaths after injury and minimizing disability, regulatory agencies should revise research regulations and reduce misinterpretation of the regulations through policy statements (i.e., guidance documents).**

In the process of implementing this recommendation, the following issues are points to consider:

- Prior national committees and legislative efforts have recommended that Congress, in instances of minimal-risk research where requiring informed consent would make the research impracticable, amend the U.S. Food and Drug Administration's (FDA's) authority so as to allow the FDA to develop criteria for waiver or modification of the requirement of informed consent for minimal-risk research. The present committee supports these recommendations, which would address current impediments to the conduct of certain types of minimal risk research in the trauma setting (e.g., diagnostic device results that would not be used to affect patient care).
- For nonexempt human subjects research that fall under either HHS or FDA human subjects protections as applicable, DoD should consider eliminating the need to also apply 10 U.S.C. 980, "Limitation on Use of Humans As Experimental Subjects" to the research.
- HHS's Office for Civil Rights should consider providing guidance on the scope and applicability of the Health Insurance Portability and Accountability Act (HIPAA) with respect to trauma care and trauma research such that barriers to the use and disclosure (sharing) of protected health information across the spectrum of care (from the prehospital or field setting, to trauma centers and hospitals, to rehabilitation centers and long-term care facilities) will be minimized.
- The FDA, in consultation with DoD, should consider establishing an internal Military Use Panel, including clinicians with deployment experience and a patient representative(s) (i.e., one or more injured soldiers), that can serve as an interagency communication and collaboration mechanism to facilitate more timely fielding of urgently needed medical therapeutic and diagnostic products for trauma care.
- In trauma settings in which there are unproven or inadequate therapeutic alternatives for life-threatening injuries, the FDA should explore the appropriate scientific and ethical balance between premarket and postmarket data collection such that potentially life-saving products are made available more quickly (after sufficient testing). At the same time, the FDA should consider developing innovative methods for addressing data gaps in the postmarket setting that adhere to regulatory and statutory constraints.
- Consistent with its approach to applications for rare diseases, the FDA should consider exercising flexibility in evidentiary standards for effectiveness within the constraints of applicable law when a large body of clinical evidence (albeit uncontrolled) supports a new indication for an FDA-approved product for the diagnosis or treatment of traumatic injury, and pragmatic, scientific or ethical issues constrain the conduct of a randomized controlled trial (e.g., on the battlefield or in the prehospital setting).
- A learning trauma care system involves continuous learning through pragmatic methods (e.g., focused empiricism) and activities that have elements of both quality improvement and research. HHS, when considering revisions to the Common Rule, should consider whether the distinction it makes between quality improvement and research permits active use of these pragmatic methods within a continuous learning process. Whatever distinction is ultimately made by HHS, the committee believes that it needs to support a learning health system. Additionally, HHS, working with DoD, should consider providing detailed guidance for stakeholders on the distinctions between quality improvement and research, including discussion of appropriate governance and oversight specific to trauma care (e.g., the continuum of combat casualty care, and prehospital and mass casualty settings).

#### RECOMMENDATION 9

##### **All military and civilian trauma systems should participate in a structured trauma quality improvement process.**

The following steps should be taken to enable learning and improvement in trauma care within and across systems:

- The Secretary of HHS, the Secretary of Defense, and the Secretary of the VA, along with their private-sector and professional society partners, should apply appropriate incentives to ensure that all military and civilian trauma centers and VA hospitals participate

#### RECOMMENDATION 10

##### **Congress, in consultation with the U.S. Department of Health and Human Services, should identify, evaluate, and implement mechanisms that ensure the inclusion of prehospital care (e.g., emergency medical services) as a seamless component of health care delivery rather than merely a transport mechanism.**

Possible mechanisms that might be considered in this process include, but are not limited to:

- Amendment of the Social Security Act such that emergency medical services is identified as a provider type, enabling the establishment of conditions of participation and health and safety standards.

#### RECOMMENDATION 11

##### **To ensure readiness and to save lives through the delivery of optimal combat casualty care, the Secretary of Defense should direct the development of career paths for trauma care (e.g., foster leadership development, create joint clinical and senior leadership positions, remove any relevant career barriers, and attract and retain a cadre of military trauma experts with financial incentives for trauma-relevant specialties). Furthermore, the Secretary of Defense should direct the Military Health System to pursue the development of integrated, permanent joint civilian and military trauma system training platforms to create and sustain an expert trauma workforce.**

Specifically, within 1 year, the Secretary of Defense should direct the following actions:

- Ensure the verification of a subset of military treatment facilities (MTFs) by the American College of Surgeons as Level I, II, or III trauma centers where permanently assigned military medical personnel deliver trauma care and accumulate relevant administrative experience every day, achieving expert-level performance. The results of a needs assessment should inform the selection of these military treatment facilities, and these new centers should participate fully in the existing civilian trauma system and in the American College of Surgeons' TQIP and National Trauma Data Bank.
- Establish and direct permanent manpower allocations for the assignment of military trauma teams representing the full spectrum

in a risk-adjusted, evidence-based quality improvement program (e.g., ACS TQIP, Vizient).

- To address the full continuum of trauma care, the American College of Surgeons should expand TQIP to encompass measures from point-of-injury/prehospital care through long-term outcomes, for its adult as well as pediatric programs.
- The Center for Medicare & Medicaid Innovation should pilot, fund, and evaluate regional, system-level models of trauma care delivery from point of injury through rehabilitation.

- Modification of CMS's ambulance fee schedule to better link the quality of prehospital care to reimbursement and health care delivery reform efforts.
- Establishing responsibility, authority, and resources within HHS to ensure that prehospital care is an integral component of health care delivery, not merely a provider of patient transport. The existing Emergency Care Coordination Center could be leveraged as a locus of responsibility and authority (see Recommendation 4) but would need to be appropriately resourced and better positioned within an operational division of HHS to ensure alignment of trauma and emergency care with health delivery improvement and reform efforts.
- Supporting and appropriately resourcing an EMS needs assessment to determine the necessary EMS workforce size, location, competencies, training, and equipping needed for optimal prehospital medical care.

of providers of prehospital, hospital, and rehabilitation-based care to civilian trauma centers. Provision should be made for these teams to obtain experience in prehospital care, burn care, pediatric trauma, emergency general surgery, and other aspects of trauma care across the system.

- Identify the optimum placement of these teams based on criteria determined by the DHA including but not limited to volume, severity, diversity, and quality of care outcomes of trauma patients at the civilian trauma centers, as well as the required number of teams as determined by a comprehensive DoD assessment.
- Develop and sustain a research portfolio focused on optimizing mechanisms by which all (active duty, Reserve, and National Guard) military medical personnel acquire and sustain expert-level performance in combat casualty care, to include research on evolving training modalities and technologies (e.g., simulation, telemedicine).
- Hold the DHA accountable for standardizing the curricula, skill sets, and competencies for all physicians, nurses, and allied health professionals (e.g., medics, technicians, administrators). The development of these curricula, skill sets, and competencies should be informed by data from the DoD Trauma Registry and DoD-developed clinical practice guidelines (including tactical combat casualty care and JTS guidelines); best civilian trauma care practices, outcomes, and data; and professional organizations representing the full spectrum of the military trauma care workforce. The JTS should validate these curricula, skill sets, and competencies.

TO DOWNLOAD THE FULL REPORT AND TO FIND ADDITIONAL RESOURCES, VISIT  
[WWW.NATIONALACADEMIES.ORG/TRAUMACARE](http://WWW.NATIONALACADEMIES.ORG/TRAUMACARE)



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 University of Maryland  
 Western Maryland Regional Training Center  
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 Cresaptown, MD 21502-5153

EMS Class Update in Allegany / Garrett County (note: may not reflect entire schedule)

Report Date: January 16, 2017

Class	Log Number	Location	Start Date	Days	# Students	Status
EMT	-	WMRTC	8/17/16	W/Su	25	Testing
EMT	-	Friendsville	9/26/16	M/Th/Sa	12	Active
EMR Refresher	-	Flintstone	10/14/16	F/Sa/Su	7	Completed
EMT Refresher	-	Garrett College CTTC	11/5/16	Sa/Su	(1)	Canceled
EMT Refresher	-	WMRTC	12/3/16	Sa/Su	15	Completed
EMR	-	Grantsville	1/3/17	Tu/Th	12	Active
EMT	-	SGCRS	1/10/17	Tu/Th/Sa	(6)	Canceled
EMT	EMS-106-S061-2017	WMRTC	1/17/17	Tu/Sa	(30)	Active
<i>*EMR Refresher</i>	<i>EMS-207-S011-2017</i>	<i>Orleans</i>	<i>3/17/17</i>	<i>F/Sa/Su</i>	<i>(1)</i>	<i>Open</i>
<i>*EMT Refresher</i>	<i>EMS-203-S048-2017</i>	<i>Eastern Garrett</i>	<i>3/18/17</i>	<i>Sa/Su</i>	<i>(5)</i>	<i>Open</i>
<i>*EMT Refresher</i>	<i>EMS-203-S050-2017</i>	<i>WMRTC</i>	<i>4/22/17</i>	<i>Sa/Su</i>	<i>(0)</i>	<i>Open</i>
<i>*EMT Refresher</i>	<i>EMS-203-S049-2017</i>	<i>Garrett College CTTC</i>	<i>5/6/17</i>	<i>Sa/Su</i>	<i>(2)</i>	<i>Open</i>
<i>*EMT Skills</i>	<i>EMS-202-S027-2017</i>	<i>WMRTC</i>	<i>6/11/17</i>	<i>Sa/Su</i>	<i>(1)</i>	<i>Open</i>

Notes:

1. Numbers in parentheses indicate total preregistered students
2. \*red color, bold, and italicized font indicates additional enrollment needed for class to start

Additional Information

1. Preregister online at <http://www.mfri.org/cgi-bin/schedule.cgi?S=Online> for the following training opportunities:
  - EMT Refresher (12 hour) – February 1
2. All registrations for MFRI are now done online!
3. New EMT and EMR curriculum are showing significant student success in the classroom and NREMT testing.

## MEMA NEWS

### 1) Current initiatives at MEMA:

- a) Maryland Emergency Management System – “the proposed replacement to MEPP. The system more accurately reflects the current way we do business and reduces burdens on our EM stakeholders. Key changes include: moving from 4 operations plans to 2; instituting cross-cutting State Coordinating Functions (replacing ESF/RSF); and a focus on daily management and emergency management coordination beyond physical face to face coordination in an EOC.” ESF Numbers will go away and the actual Function will be specified. A standardization of EOC activation levels is also a part of the new system.
- b) Resource List- MEMA is again developing resource lists that will be maintained at MEMA. This initiative will include credentialing and defining equipment and personnel (specialized teams) and developing lists to be maintained at MEMA in the MJOC and the SEOC. Search and Rescue asset lists are well on the way to being completed and fire and emergency services is next.
- c) Local Emergency Managers Guide- MEMA is developing this guide “to assist new Emergency managers with their orientation to the support MEMA can provide through the MJOC/SEOC, and provide them with reference information and documents that may be used during activation.”

### MEMA Webpage

Please visit MEMA’s webpage to get the latest information on Emergency Management and programs at the agency. The Homepage has a lot of good general information; a Citizens page has good preparedness information for the general public; an Emergency Community page has information on programs at MEMA and Emergency Management throughout the state; and a Business and Non-profit page that includes a section on “Preparedness resources for Business”, “Private Sector Integration Program”, and “Osprey Business”.

### Exercise and Training

- 1) MEMA Learning Management System - Training and exercise events will be posted on the MEMA LMS Events Calendar, similar to the current training and exercise calendar. To register for an upcoming event, you will need to be registered with the LMS; registration requires a Federal Emergency Management Agency (FEMA) Student Identification (SID) Number.
  - a. FEMA SID Number: <https://cdp.dhs.gov/femasid/>
  - b. MEMA LMS: <https://memamaryland.csod.com>
- 2) WebEOC Drills- MEMA is conducting monthly WebEOC drills. If you use WebEOC, I urge you to take part in these drills.

- 3) Training – Please check the MEMA LMS Events Calendar for available training. The listing below includes offering at DEMA, EMI, and others:
- 4) MEMAC Drills- These will continue to be quarterly in 2017.
- 5) Critical Decision Making for Complex Coordinated Attacks, Washington Co EOC, April, 2017
- 6) The latest DHS Partnership Bulletin and wanted to make you aware of a free IED training resource called IMPACT. It's listed in the DHS OBP Counter-IED Resources Guide on the last page. We have a user in Harford County, MD.

IMPACT is a free all-hazards planning tool for first responders. It is meant to augment, not replace, current tools you may already be using. It tries to fill a special niche by providing the following features:

- Simple to use by non-GIS professionals
- Custom map making and data collection
- Con-ops simulation for table-top exercises
- Real-time data feeds for situational awareness
- GPS tracking of people and assets
- Automated report generation
- Desktop or laptop operation (tablets via remote desktop)
- Windows, Macintosh, and Linux support
- Operational with or without a network connection in the field
- Free

Some possible uses include:

- IED, evac, and shooter line-of-sight table-top exercises
- Severe weather monitoring/alerting with geofences
- Hazard impacts to population using built-in population database
- Use in response vehicles for asset tracking/webcam damage surveys
- Special event and shelter placement planning
- Radio communications placement
- Traffic/security web camera monitoring

If there is interest I can help in providing classroom training or a State wide webinar.

### **Western Region RLO Status Report, Western Region Update**

#### **a. Key on-going emergency management planning**

- o Washington, Allegany, & Garrett Interoperability Network (WAGIN)
- o Washington Co Multi-Agency Active Assailant Response Plan is still in development.

- Washington Co-Training facility design and site planning continuing
- Allegany and Washington Co to obtain FEMA approved Debris Management Plans
  - Migrating to MD First
  - Western MD IMT developing, now including Frederick Co
  - Regional I & II Health Care Coalition tabletop exercise, March 8.
- Garrett Co developing active shooter multi-agency response plan
- Garrett Co EOC received MEMA furniture donations

**b. Upcoming emergency management training**

- David Johnston, DHS-PSA to conducted briefing for EMs on Enhanced Critical Infrastructure Protection Visit and the Infrastructure Survey Tool

**c. Upcoming emergency management exercise**

- Washington Co Airport full scale exercise, April 10
- Garrett Co, Active Shooter, TBD