Jurisdictional Advisory Committee -Virtual Meeting

February 9, 2022
10:00 AM to 12:00 Noon
653 West Pratt Street
Baltimore, Maryland

Meeting called by:	Christian Griffin, Chairman

Agenda Topics

10:00 AM	**Welcome and Introductions**	Christian Griffin
10:05 AM	**Approval of JAC Minutes – December 2021**	Christian Griffin
10:05-10:30 AM	**OMD Update**	Dr. Chizmar
10:30-10:45 AM	**Office of Clinician Services Update**	Bev Witmer
10:45-11:00 AM	**Emergency Operations Update**	Randy Linthicum
11:00-11:15 AM	**Field Operations Update**	Jeff Huggins
11:15-11:30 AM	**EMS-C Update:** • **Status of Assessment**	Cyndy Wright-Johnson
11:30-11:45 AM	**Jurisdictional Roundtable**	Christian Griffin

Meeting ID
Jurisdictional Advisory Committee
[redacted]

Phone Numbers
[redacted]

JAC Meeting – February 2022

The February 2022 JAC Meeting was called to order by Dr. Chizmar who proceeded to take attendance for the meeting. Attendance Sheet is attached to the Minutes. The meeting was then turned over to Chair Griffin who said that the Minutes from the December JAC Meeting were sent out with the meeting invite to the Committee earlier. A motion to approve the Minutes was made by Baltimore City, Chief Matz, 2nd by Salisbury Chief Truitt. Minutes were unanimously approved.

OMD Report: Dr. Chizmar provided a PowerPoint. Regarding COVID-19, currently hovering around 1093 adults with 23 children in acute care and ICU beds. A marked improvement this past month. May see some blips, particularly in the yellow alert usage as hospital's come off crisis standards of care and reinitiate their operative schedules. PUI line is continuing to trend downward which is good. Thanks to all the clinicians who are very diligent about logging the data. The Governor's Office continues to very closely monitor this.

Dr. Chizmar provided a recap regarding the State of Emergency that the Governor declared on January 4, 2022 that lasted for 30 days and was not renewed as he announced in his State of the State last week. Some of the temporary terminations EMT and CRT vaccinators were being done through a public notice that was tied to the State of Emergency. Vaccination is in the law, in the Statute and cannot be changed without the legislators changing the Statute. CRT and EMT vaccinators are done as of February 3rd. Testing before completion of EMT field internship is something that stopped formally with the State of Emergency but they have an emergency regulation in place that will change this back. Essentially allowing either written testing before field internship or field internship first. They are in the process of effecting a permanent fix by emergency regulation. This will be stopped for a short period of time but will be restarted. The extension of licenses from the end of 2021 until June 30, 2022, those licenses are still active and extended until June 30, 2022. So everyone received a six month reprieve, that otherwise would have expired at the end of 2021. The provisional license, there were two rounds of provisional. The round with the first State of Emergency in 2021, allowed those provisional licensees initially until February 11, 2022 to fully license to make the requirements for full licensure. That was extended with the second State of Emergency until May 11, 2022 to convert to full licensure. The second round of provisional licensees unfortunately that process was only open just for the month of January with this State of Emergency. They did have a small number of EMTs and paramedics that were able to do that. Those CRTs and paramedics will have until November 30, 2022 before they are required to complete the requirements for full licensure or they would otherwise expire. Clinical externs and respiratory therapy was tied to the emergency order as well and was stopped, which was providing additional staffing to the hospitals as well.

In terms of supply change shortages, cardiac epi pre-filled syringes, saline flushes, defib pads and there are other sporadic medication shortages out there. Dr. Chizmar asks that you let him know if there are other medication shortages that are unsurmountable and he will try and find a way to connect you to a supplier or he will try and find a way to work around it. He does not yet have a good solution for saline flushes. A memo went out regarding this. He asks that all be very careful not to premix or change the container of a medicine including saline ahead of time and store it that way. That brings up risk of contamination and risk of losing efficacy of the medicine especially when it concerns epinephrine. The memo Dr. Chizmar just referred to is posted on the MIEMSS website in case you need to refer to it. Regarding defib pads, to clarify this Dr. Chizmar would rather have expired defibrillation pads out there than taking monitors out of service for lack of defib pads. He feels there is the need to exercise a bit of

judgment when it comes to that. If you have defib pads that expired yesterday, exercise a bit of common sense instead of taking that entire monitor device out of service. Expiration within the past six months, they are reasonable to use.

The EMS Board approved the new protocols for 2022 yesterday at their Board meeting. The protocols will go live on July 1, 2022. They will be working with the Office of Education to develop the education for the protocols. There is one notable exception and that is TXA. The Board was willing to go and allow certain jurisdictions to go live with that if the training was done by the jurisdiction to the satisfaction of MIEMSS. They are developing training for TXA. There are certain jurisdictions, MSP Aviation Command among them, who felt a pressing need to have TXA as soon as possible. Dr. Chizmar said it will take people time to stock it and it will take people time to get their clinicians in front of the education. He is not necessarily asking people to rush and roll TXA out, but if you have TXA sitting on the shelf and have done training with your people, let Dr. Chizmar know and he might be able to turn it on a bit early for you. TXA is one that Dr. Chizmar spent the past two years with the trauma surgeons going over with a fine tooth comb. They will be reviewing every single case that TXA is given for appropriateness and complications. He wants to make sure that their messaging is clear. TXA can be a really big issue. He does not want to rush the implementation.

Critically unstable patient, the protocol is in addition to the GPC with the stand alone piece that talks about resuscitating patients, particularly medical patients, resuscitate them prior to moving the patient. Dr. Stone and colleagues from Montgomery County looked at data from out of state and we know when we pick up a patient and start running, that a certain portion of those patients go into cardiac arrest or decompensate. With regard to CPR a culture change was made a couple of years ago whereby everything is brought to the patient, we are going to do CPR when the patient collapses, we are not going to just scoop and run. Dr. Chizmar said we know if we are addressing the airway, breathing and circulation to the extent possible on scene, before we start scooping and running, the patients do better. There are no new procedures, no new medications with this protocol. The caveat to this goes without saying, if the scene is unstable or dangerous, there is still allowance to move. Really want to direct people to optimize the outcome of the patient.

The second one is the Ventricular Assist Device for the VAD protocol. These devices have been put in by a variety of tertiary care centers. Among them are Hopkins, Maryland and MedStar. Patients are out in the community, they are living longer with these devices and we are going to encounter them. This is not everything from A to Z on VADs. This is what you have to know in a pinch when the person in front of you is unstable. It addresses events like suction events when patients are hypotensive, unconscious and they have a VAD. It also addresses situations like cardiac arrest. Manual CPR is what is recommended. There are also helpful numbers for the VAD coordinators at all the major centers in the State and D.C.

New Medications: Will be adding Droperidol, is in the same family as Haloperidol and is a little faster acting. This will be an ALS medication, added for moderate agitation. Because of drug shortages will put Haloperidol on the back shelf. The key difference with this is, it is not approved to go down quite so far in the age range. There will be some patients, particularly those 12 and under, where they will resort to Midazolam. Dr. Chizmar ran the Haldol numbers and there were less than 10 cases per year in which Haloperidol was used for the 12 and under.

TXA: Covered extensively above. For treatment of traumatic hemorrhagic shock in patients 15 years of age and older. State Police will start carrying this as of 0700 today. This will be integrated as part of their transition to whole blood.

Acetaminophen: All patients ages 3 months and older may now receive Acetaminophen for treatment of fever (EMS-documented temperature of 100.4 or greater) or mild to moderate pain. Important that the actual temperature is documented if giving Acetaminophen for fever.

Extraglottic Airways: This is a particularly important protocol. This addition allows for the use of extraglottic/supraglottic airways including the King LTS-D, LMA, Air-Q and iGel. An EMSOP must select one of these airway devices and carry sizes appropriate for all patients from newborn through adult. These devices serve a critically important role in assisting ventilation and oxygenation to patients with compromised airways. If your jurisdiction wants to cut over to one of these, your medical director and your training officer must be involved in the training of everyone. There will be a learning management system in place lead by Dr. Galvagno, an anesthesiologist at Shock Trauma who will walk through the didactic portion of this. This is a discussion to take back to your jurisdictions and let Dr. Chizmar know where you stand with this.

PEA/Asystole: The adult PEA/Asystole algorithm has been refined to provide focused guidance on the management of patients in asystole, PEA with a narrow QRS, and PEA with a wide QRS. Calcium chloride and sodium bicarbonate should only be given for PEA with a wide QRS. The medical consultation requirement for sodium bicarbonate administration in adults has been removed.

Lateral Uterine Displacement: Something that we should have been explicit on for quite some time. For pregnant patients with hypotension or cardiac arrest, specific guidance has been added to provide left lateral uterine displacement with a goal of increasing venous return.

Induced Hypothermia: Removing from field management. Based on recent high-level scientific evidence, induced hypothermia has been removed.

There is an OSP available for Hydrofluoric Acid (HF) exposure. HF has been around for quite some time in a variety of different manufacturing industries. This came to Dr. Chizmar as a submission from the Howard County Haz Mat Team. Due to increased risk of HF exposure from electric car batteries, this OSP has been added to allow for calcium gluconate via IV, topical and nebulized routes. Interested jurisdictions should submit an OSP application to the State EMS Medical Director.

Direct to Triage: Chief Sabat was ahead of his time in proposing this. This will be incorporated in the primary protocol book. Almost everyone statewide has rolled this out. The hospital turnaround times have gotten better. Congratulations to everyone who pulled this off. For statistical purposes this field was added to eMEDS.

Opioid and Naloxone Use: There is currently a bill in the legislature that would further enable the naloxone leave behind program. Naloxone Leave Behind is done in 19 of the 28 public safety jurisdictions. We do it through an order through MDH that allows us to dispense medication, but otherwise it is against the law for us to dispense medication. There is a proposal in the General Assembly now that would add it to the EMS law that would say EMS can dispense medication. The law would be permissive but not requiring. Senate Bill 394

Quality Improvement: The MIEMSS Quality Improvement Officer course is now fully launched online. Dr. Chizmar would like to engage this group and your QI officer quarterly to look at some the metrics he has been following. He will ask at the end of the meeting how you would like to go about this.

Dr. Chizmar has been attending the PSAP statewide meetings run through MACO. One survey that he put out to the jurisdictions and received 15 responses on was how many PSAPs are tracking the hands on chest time. The time from which the 911 caller makes the initial call into the center until the time we actually get bystander hands on chest. He shared that approximately one-half of the 15 responses are not currently tracking hands on chest time. He feels this is something all can be working collaboratively with the PSAPs moving forward. PSAPs if not tracking a metric we have no idea how we are doing. In particular, we do not know if we are getting better or getting worse. PSAP hands on chest time is a measure Dr. Chizmar offers as a PSAP measure of quality. Dr. Chizmar asks the group to have a conversation with your PSAPs.

C4/Pediatric continues to provide service. Dwayne Kitis is on the call and has been coordinating this with the intensivists along with Alex Kelly. This has been a critical asset for the state to try and offload some of the E.Ds. The phone number for C4 is (410) 706-7797.

Meeting with the stroke QIC and stroke neurologists. Talking about expanding the referral interval for the large vessel occlusion strokes. These are the LAMS 4 or greater people. Currently we use 30 minutes; Dr. Chizmar is working with the neurologists to see if we can expand the time envelope outward to 45 minutes if we can do this safety and without depriving anyone the ability to get TPA.

Pediatrics will be bringing a seizure research protocol forward in March to the PRC. This will predominantly affect the National Capital Region, predominantly Prince George's County. Where instead of weight based dosing they will be looking towards basing the Midazolam on the child's age range. Dr. Chizmar thinks the thought process is there, might be some delay in administration of Midazolam.

Conferences: Winterfest and Miltenberger conferences have been migrated to online. The April JAC is replaced by the Annual EMS Medical Directors' Symposium. You are asked to mark your calendars for the morning of April 13th, 8 am until 12 Noon. Dr. Chizmar understands EMS Care will still be held in person. They are in the process of pulling together the speakers and topic list as he speaks.

Question was asked if you can audio and video record patient interactions in the back of the ambulance. After speaking with Sarah Sette, Assistant Attorney General's Office, you have to have consent from the person for audio or video recording or both. Make sure both are documented. If the device you are using is not secure or encrypted, he recommends caution or speak with your council.

Bev Witmer, Office of Clinician Services: Regarding the Internship Packet – if a student does show up to state testing without the internship packet they will go ahead and test them. However they will not get their certification processed until their certification packet is turned in. The ALS renewal applications were opened on February 1st and are due 14 days before they expire. The Lunch time PDI has been a huge success averaging 30 to 35 instructors present. The next one is March 3rd at 12 Noon discussing Personality Traits for the Instructor and how that applies to educational theory. Registration link will be up and available to register by the middle of February. The office is requesting that service directors be on the look for an e-mail from her office for directions on how to go in and look at who your service directors are, verify agents, and such. They ask that you look them over. Check your e-mail addresses

and mailing addresses also, they have had a lot of mailings returned. Online training center is being updated with the goal of completion by March 1st. Partnering with Loyola College for an EMS based course that will teach folks how to interact with patients with intellectual disabilities and how to make interaction during an emergency more positive for the patient and the crew.

Randy Linthicum: EMS Care coming up in May. Will be offering a couple of CISM related courses as preconference. On May 11-13 they will offer a three day initial CISM group and individual training. On that Friday, will offer training all day on mental health and a first aid course.

Cyndy Wright-Johnson: Cyndy had previously sent out updates, additionally she provided a power point today. Committee was reminded to get your nominations in for Right Care When It Counts and Star of Life due March 25th.

Jurisdictional Roundtable

Annapolis City: They have five new paramedics in the field. They have a new person in their EMS Division who will be looking at the telemedicine and alternative destination reports

Anne Arundel County: Would like to express their condolences regarding the recent LODDs in the past weeks. Now getting back to QA/Qi and EMS directives. Anne Arundel Community College is looking to sponsor a train the trainer program on Stressors on the Job at the supervisor level. More information to follow.

Baltimore City: Thanked everyone for their kind words and condolences and support. Last time they lost that many people was in 1955. Emergency Service Transport Supplemental Payment Program, Chief Matz recommends to start looking at this. For Baltimore City, it's worth tens of millions of dollars. They are in the final stage of an audit. Have left over 2100 kits for the Leave Behind.

Baltimore County: Working on a contingency plan after COVID surge. Advertising for an Assistant Medical Director position. They have an EMS recruit class graduating tomorrow night. They are undergoing a third party analysis for the fire department, but the county government is also undergoing an overall efficiency analysis.

BWI: The Urgent Care Center has exceeded all of their expectations. Annual visits are well beyond the business model. They are already looking for bigger real estate at the airport. Next week is their cadaver lab/airway lab. There is a serious homeless problem at BWI, saving for Region III. There is not a lot of collaboration. One recruit started in the Anne Arundel County Fire Department.

Calvert County: They just finished their cadaver lab. Job offers were made to five paramedics. This July intend to add 12 additional positions to career.

Carroll County: They had a LODD directly related to COVID, Bobby Jones. Held a LODD funeral. Cooperation was significant. Within the next week or two will be advertising for two manager positions, Chief Officer for EMS and second position, Training Officer, and Health and Safety Officer. Working on their budget; looking at 60 positions as of July 1st. Working with their opioid group in Carroll County to implement the Leave Behind Narcan.

Caroline County: Just hired their training lieutenant. Still working on the Leave Behind. Hopefully within the next month or so can get that up and running. Still looking for a medical director.

Cecil County: One paramedic in field training, have hired an additional EMT. Regarding the Leave Behind Narcan, have partnered with their local health department.

Dorchester County: Lots of training going on, advanced airway, ultrasound training and conducted skills and refresher training.

Garrett County: They have a new chase unit that will be going into service within the next few days. This will free up an old unit for their community resource team of EMTs and paramedics that will work with the health department and follow overdose and substance abuse in the community.

Howard County: They have officially switched all LMAs to i-Gels. Have completed training on all their medication pumps for the ALS personnel and distributed one pump for all front line ambulance and medical supervisor car. Similar to Baltimore City, they have implemented the EMS Surge Plan. The idea is to have a consistent operational plan for when they are low on ambulance availability and find best practices.

Prince George's County: In meeting with the hospitals, one thing they started was reports on hospital drop times. Hospitals have been receptive and responsive. Have received their first batch of naloxone kits, certainly not enough but should receive the next batch within the next week or two.

Queen Anne's County: Small recruit class of five in right now. Will be finished up within the next week or two. Helping their brothers and sisters in Ocean city with training, ultrasound. Upcoming fiscal will be opening another station in the southern part of the county.

Salisbury: Planning for their marathon in April. Planning on adding some front live supervisors to EMS.

MSP: There are six new medics starting. TXA is being carried on the aircrafts as of today.

Ocean City: Thanked MIEMSS as well as others who assisted them in becoming an EMSOP. They have 11 part-time positions and hoping to add 16 full-time positions. Their call volume is up 12 percent as compared to last year.

Next meeting will be the Annual EMS Medical Directors' Symposium – Virtual
April 13, 2022