Region IV EMS Advisory Council

Chris Truitt, Chair
Chris Shaffer, Vice-Chair
KJ Marvel, Secretary

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AGENDA
November 21, 2023

1. Call to Order & Introductions
2. Approval of Minutes
3. Regional Medical Director's Report
4. Pediatric Medical Director's/EMSC Report
5. EMS Board Report
6. SEMSAC
7. Regional Affairs Report
8. MIEMSS Report
9. Agency/Regional Reports (Circle "yes" on the roster if you want to make a report)
10. Old Business
11. New Business
12. Adjournment

Next meeting
January 16, 2024
@ 1330 hrs.
605 Port Street
Easton, MD 21601

REGION IV EMS ADVISORY COUNCIL
November 21, 2023
Minutes

Attendees

In Person: Bryan Ebling, Michael Parsons, Chris Truitt, Cyndy Wright-Johnson, Dr. Ochsenschlager, Tina Kintop, Chris Schaffer, Yelitza Davis-Hernandez.

Call In: Falon Beck, Doug Walters, Harvey Booth, Holly Trice, Matt McCormick, Kathy Jo Marvel, Lisa Lisle, Mary Alice Vanhoy, Nicole Leonard, Randy Linthicum, Kristin Dietz, Logan Quinn, Rick Koch, Scott Haas, Dr. Chizmar, Dr. Chiccone, 1st Sgt. Larson, Dr. Uribe, Debbie Wheedleton, Zach Yerkie, Morganne Castiglione.

The meeting was called to order at 1:36 by Chairman Chris Truitt

Approval of Minutes: A motion was made by Chris Shaffer to approve the September 19, 2023 minutes as written, seconded by Rick Koch and passed.

Regional Medical Director's Report:

Dr. Chiccone – I have some updates from the last Protocol Review Committee meeting, which was held on November 8th. I mentioned to you at our last meeting that there was under consideration a significant protocol, which will now be a titled Persistent Tachycardia Ventricular Fibrillation, and it is my understanding that the protocol has now passed at the committee level. In addition, the dive medicine optional supplemental protocol, which Dr. Tang and Dr. Kent presented, has also passed. Just to be clear, this is search and rescue diving as opposed to diving in a hyperbaric chamber. Another item, which passed, had to do with destinations for burn and trauma patients. The goal here was to try to simplify and be clear that when a patient is significantly burned the patient belongs at a burn center and this would include airway burns. There was also a carbon monoxide protocol that passed and the proviso there being that burns go to the burn center.

A question had arisen about a patient's ability to refuse/deny care. Should there be an absolute limit for a blood pressure concerning the ability of a patient to be able to refuse/deny care? Dr. Stone made the following proposal, blood pressures at 240/140 for non-symptomatic and 220/120 for symptomatic. This was tabled for further discussion in January.

There was a proposal, which came from Worcester Mobile Integrated Community Health. They are looking to expand the scope of service to include the ability to draw labs because personal transportation can be an issue in Worcester. Also to obtain electrocardiograms for interpretation. A paramedic on scene would provide the interpretation and it would only be to look at the

cardiogram and rule out threatening processes. The responsibility for the final interpretation would be with the ordering Physician or the ordering Physicians designee.

We had an interesting item that will become part of the general patient care section. As a reminder, if a patient does not speak English, there is a protocol in place that as soon as it is feasible in the patient's care, language line consultation should be obtained. Prior to this coming to protocol review, PSAPS had been meeting with MIEMSS for a long time and came up with this item. Frequently it will be a family member who will provide emergency interpretation. However, there are a couple of warnings about having family members interpret. That said, the goal would be to contact Language Line through your local Dispatch as soon as it is feasible.

The drug Rocuronium was added as a paralytic and this would apply just to RSI pharmacology.

Another item, which was passed, was the proposal that tactical EMTs within the scope will now be trained if they desire to use i-gels as a supraglottic airway.

Again, for RSI, in a situation where there is ventilatory difficulty a proposal had come forward for repeat etomidate dosing. That was tabled and what did pass was the substitution of a ketamine drip. Again, this would apply only to Jurisdictions having RSI protocols.

Another piece of discussion that was held over for January was in a situation where CPR is effective enough that the patient recovers some level of consciousness, which is referred to as CPR induced consciousness, there was a proposal to use ketamine in that situation.

With regards to the overdose and poisoning protocols, as opposed to a substantive change, a prompt will added and appear in the protocol to stimulate and remind people about recovery resource referral in those cases.

The last thing I wanted to bring up was not from protocol review, but this was information that came from our Medical Directors the call in October. The EMS board receives data regarding our QA and QI for the state and the board observed a trend in bad outcomes. They mentioned that a good number of cases in which there were bad outcomes had a unifying factor namely that ALS monitor or ALS bag or both did not come inside for the initial evaluation of patients. The bad outcomes included things like patients with myocardial infarctions (MI’s) being walked out to the ambulance and then deteriorating after they were outside. They had not been previously monitored and then only to discover that there is now some horrendousness dysrhythmia in progress. The board mentioned this because they are surprised and wondered why ALS bags and monitors are not going in on calls. I think it was consciousness raising for rank and file to come forward with a workable solution. I would try to discourage actively having the board or any other authority dictate a solution to this problem. Although I think, the solution is evident in that patients should have what is needed at their side on the initial encounter.

Pediatric Medical Director's/EMSC Report:

Cyndy Wright-Johnson – We had our PEMAC meeting before the protocol meeting and Dr. Chiccone has covered all of that information. We are continuing to work with the Pediatric centers that do ECMO. Just as Hopkins and Maryland will be available for adults that limited protocol will also apply to children. We are working out some of those details, the ECMO teams at Children's, Hopkins and Maryland need to talk and work together. We realize that this is a very limited geographic area and I do not honestly see more ECMO centers coming onboard in the short-term basis.

The only other protocol that we are looking at is the use of TXA. PEMAC will discuss that in two weeks and then make a recommendation to Dr. Chizmar.

We had a very robust research forum this month, we had a number of people call in and a number of people there with us in the afternoon. We also did five top articles and not only did we have someone present the five top articles, we had one of our pediatric EMS Champions react to it; how would it change my practice? The suggestion was made that we not just do the five articles once a year, but do it on a more regular basis.

I believe I can tell you that we have 29 of 29 Pediatric EMS Champions. We have someone for Somerset and we are just waiting on his paperwork.

We are doing a PEPP course at the request of Wicomico County on December 4th. As of noon yesterday, we had 13 people registered. I talked to Danielle Joy as I was driving down and she is willing to leave the class open for another week. We will close it on the 27th of November. There is 10 hours of prep work ahead of time that you do online before you come to the course.

We will not be doing a PEPP course at Winterfest or at Miltenberger because people have requested us to do the simulations. Therefore, we will do pediatric simulations on the first Friday in February at Chesapeake College as part of Winterfest and the second Friday of March at Rocky Gap at the request of the Miltenberger conference. That said, we do have the funding to run three other PEPP courses during the next calendar year.

I think we are up to 20 out of 49 hospitals that have identified a Pediatric Nurse Champion. We are doing quarterly forums with them and we have attended 3 out of 3 E&A conferences this fall and are slowly building that group. Dr. Anders is hosting the Physician side of being a Pediatric Champion on Wednesday the 29th of November and I currently have 29 people registered. They seem to be from our known pediatric resource hospitals in the Mid-Atlantic, up and down the 95 corridor as well as from Western Maryland. We are pushing that out again today to all the EMS Medical Directors and to all the Base Station Medical Directors.

Our goal for Pediatric Readiness in Emergency Departments is that every ED between now and a four-year cycle voluntarily come in at whatever level they are Pediatric Ready.

- I can recognize what a child is.
- I can triage, stabilize, and have a plan and a set of procedures to transfer.

That is what we want for all 49 EDs including the 7 freestanding facilities. There will be another level, which will include Pediatric Resources Centers. They are hospitals that can admit to an observation unit attached to an ED or actually admit to a Pediatric Unit.

Most of those are now Maternal Child Health units. So today, it has six kids and three mother babies and tomorrow or two days from now it might have six mother babies and three pediatric. That is how most of them are running, even the largest ones like Holy Cross where they deliver 3,000 babies a year. It is a flex unit, it is no longer just pediatric beds and if they are not in use, they are idle. They flex them back and forth and have the resources, procedures, and quality improvement to have that happen.

Then there are the Pediatric Critical Care Centers, we have never had a mechanism to recognize for example University of Maryland or Sinai, which have Pediatric Intensive Care units, but are not a trauma or burn center. We are working on building that in and the EMS board has given us the green light. We are in draft form and hope to bring that to the board after the first of the year, either at the January or March meeting.

I brought with me copies of the previously emailed handouts and the flyers for the physician meetings if anybody wants them.

At this time, we do not know where or when EMS Care will be. They are looking at some time in the fall and somewhere on the Western Shore, just not in Western Maryland because that is Miltenberger's conference space.

I want to be able to give all our Pediatric Champions our meeting dates by the beginning of January so EMS Care in October should be a placeholder because that committee has not met yet.

Lastly, the forms are online in a Smartsheet format for this year's award nominations. I do not believe I have any children who have been nominated for Right Care When it Counts as of yet. The challenge is for each Jurisdiction is to find a child who helps somebody, taught somebody or picked up the phone and dialed 911.

The Stars of Life awards are coming in very slowly. So just a reminder, we have the following awards.

- EMS for Children Award.
- Geriatric Award.
- The Leon Hayes Lifetime Achievement Award.
- Outstanding EMS Program Award.
- EMS Clinician Award.
- EMS Dispatch Award.
- Citizen Award.
- Rescue of the Year Award.

I brought hard copies to share, however, everything can be found on the MIEMSS website including the link to submit your nominations.

EMS Board Report:

Mary Alice Vanhoy – I could not attend the last meeting so I will have to defer to Dr. Chizmar.

Dr. Chizmar – The majority of the meeting time was spent on individual compliance and disciplinary cases. There was a significant update by Dr. Delbridge on the Eddie initiative, which is the Emergency Department Dramatic Improvement Effort whereby EMS is contributing the 90th percentile transfer of care times. Dr. Delbridge is working with stakeholders and partners with the Maryland Hospital Association and others to make that part of the funding formula for hospitals moving forward. That is not finalized, just proposed at this time. They are following the times but the funding pieces is not entirely decided upon as of yet.
Dr. Delbridge also gave a report on the commission to strengthen firefighting in EMS in Maryland as well as the other commission that he is serving on that regards the way in which Trauma Centers in Maryland are funded.

SEMSAC Report:

Scott Haas – I really do not have anything additional to report. I would like to thank Dawn for continually pushing out my reports to the Region. The only other notable thing is that I was voted in as the Vice Chairman of SEMSAC for the upcoming year.

Regional Affairs Report:

Rick Koch – We met at the beginning of the month and I am not sure where everything stands right now as far as getting the purchase orders out, however, we were able to fund Kent Island, Rising Sun, Cecilton, Singerly and the Cecil County Department of Emergency Services with cardiac monitors. We were also able to increase the funding this year because we did not have that many requests from the Region. Churchill, Fruitland, Parsonsburg, and Powellville all received grants for AEDs. We were able to award all of our grant funds and we actually got a little bit of money from another region to fulfill all of the grant requests that we received. In addition, statewide we were able to use all of the grant funds that we were awarded.

As far as the status for grants awarded in FY23 go, I do not have that information in front of me at this time. Bryan, do you have any updates for FY23 grant status?

Bryan Ebling – I know that everyone has received their award letters and have ordered their equipment. Their equipment is coming in a little bit at a time. Therefore, we just want to remind everybody as soon as the equipment comes in get the invoice paid and ask for reimbursement as soon as you can.

Mobile Integrated Health:

Chris Truitt – I know for Salisbury the last time we talked about we had started our Minor Definitive Care Now (MDCN) five days a week. It has been going really well. Of course, when

the low Acuity calls it is always going to be somewhat tricky to nail that down. I hope that we can keep that going after this year's grant funding.

Harvey Booth – I have nothing to add other than what Dr. Chiccone already brought up as far as our protocol that was approved by the protocol committee. Therefore, we are anxiously awaiting the rest of that process to get that started.

Zach Yerkie – We are in the middle of trying to put a new unit together and trying to expand our program. We have two folks that are going to a wound care conference and we are going to try to look at bringing in a wound aspect to our program.

Kathy Jo Marvel – We are not up and running just yet, however, we are close. I think there is someone from our health department that have joined the meeting today. We are going to the County Commissioners on December 5th to give a little overview presentation. We have been working with our health department and they are applying for a grant. That will hopefully give us the startup funds to be able to get this off the ground in FY25. We have been working on laying out our model as far as who what we want to have. We are looking at a Nurse Practitioner and a full time Paramedic to hire and supplement with our Paramedics on the street. I did want to mention that Holly Trace and Robin Cahill have been instrumental in designing the Grant and we are very excited about that. Thank you to everybody who has answered my endless amount of questions, you all have been great.

Tina Kintop – Because of Covid and staffing our MIH project kind of slowed down. However, as of January 1st we have resurrected it and applied for the Health Equity's Grant. We have our plan laid out and now we are working toward bringing it back into fruition.

MIEMSS Report:

Dr. Chizmar – I want to say it has been great to see several of you over the past couple weeks. I was down in Wicomico County where we just kicked off the SWOT analysis. I was also able to visit with Chief Koch and his RSI Clinicians in Ocean City. I just wanted to say that I appreciate both Jurisdictions for having me.

Bryan Ebling, Randy Linthicum and I have been interfacing with MDH on what we understand as an H5N1 Avian Influenza outbreak in Caroline County. It is our understanding from Dr. Crum, the State Public Health Veterinarian who has been interfacing with Chief Marvel that no human cases have been reported. The precautions for H5N1 we verified with Dr. Crum are essentially identical to what we have been doing for Seasonal Influenza and Covid.

Dr. Chiccone covered the proposed protocols thoroughly. I would just emphasize that our next steps are to present those proposals to SEMSAC and the EMS Board at their joint meeting on January 16th.

The QA / QI Officers are meeting on a quarterly basis. What I have asked of them in an effort to improve our Cardiac Arrest survival rates is to begin recording Telecommunicator (9-1-1 Specialist) Facilitated CPR Times (TCPR) in the CARES records. That will essentially boil down to two times. The first time interval will be the PSAP call time to the recognition of a

cardiac arrest. The second time interval is that PSAP call time to the first TCPR delivered compression. Therefore, those two times are available through priority dispatch, which I understand from the PSAP Directors group that everyone is using now. So we have hosted at least two sessions now that Priority Dispatch has put on to allow your PSAPS to know how to run those reports within that software so that they can get that information and get it over to you. This is voluntary; However, I would ask that you strongly consider putting these times in the CARES record.

I believe that we have done many initiatives around Cardiac Arrest; however, one of the things we have not focused on is our performance at the 911 Center or PSAP level. Obviously, in that first five to ten minutes those are essential metrics for us to be able to measure and improve upon. Having that within the CARES record allows us to see it all in one place from the time of PSAP call, the time of initial arrest all the way through the patient's hospital course and recovery. So again, the QA officers will continue to focus on that. In addition, in the QA world, we will continue to focus on introducing some of the new newly released National EMS Quality Measures and I will be looking to them for their feedback on that.

For those hospitals that are online, we have seen in some areas of the State that the Physicians providing Medical Direction have not wanted to supply their name over the radio and they are not required to. It is public radio and anybody with a sophisticated scanner can listen to the call. Some Physicians out there are worried about the public knowing where they are. In that case, if we are not transporting to that hospital, it is certainly appropriate for the hospital to tell EMS to call the landline and then provide the name of the physician if it needs to be documented for the report. In the cases where we are transporting to that Physician's hospital, it is fine to get the Physicians name upon arrival. Therefore, in the cases where we are not transporting the patient to the hospitals that are on the line, please let your Physicians know to expect a follow up phone call.

The last piece I wanted to cover is the EMT psychomotor exam process. Many of you know that as of July 2024 for Paramedics, The National Registry will retire the ALS psychomotor exam in favor of an enhanced cognitive exam. They will have the standard cognitive exam level questions also augmented with several case scenarios, and they will rely upon the ALS education programs to maintain a portfolio of the Clinician's skills.

So as of next July there will not be an ALS psychomotor exam, or an ALS practical exam. States do have an ability to add one; however, The National Registry does not require it. At this point in time, Maryland does not have plans to add back the ALS psychomotor exam. Therefore, at the ALS level you will not have a practical exam after July.

At the BLS level, we are maintaining the BLS psychomotor exam and are making some enhancements. We have essentially slimmed down the number of stations from five stations down to two stations. We are in the process of recruiting additional evaluators to try to make as many exam dates available for BLS Clinicians who need to test. We do not have any plans to retire the BLS practical or BLS psychomotor evaluation. The National Registry has spoken about retiring that exam requirement in 2025 or sometime thereafter. The current thinking in Maryland is that we will retain that exam moving forward at the BLS level only. There are a variety of reasons for that including ensuring entry-level competency with some of the requisite skills.

With regards to the EMT continuing education model, there is currently a regulation for EMT recertification and how EMTs recertify moving forward. It is in the publication process and it is always hard to know an exact date because it goes through a legislative process. However, it will more likely than not be in play in January or February of 2024. What this does is it switches things just slightly for the EMT renewal process. So currently, there are multiple ways that you can renew your EMT.

- You can do 4 hours of medical, 4 hours of trauma, 4 hours of local option, and a 12-hour skills session.
- You can do a conventional 24-hour refresher where you get all the continuing education and skills refresher all in one.
- You can continue to maintain your National Registry EMT and send MIEMSS the card.

Moving forward the regulation that has been reviewed by SEMSAC and the EMS Board will state that you can continue to maintain your National Registry EMT as a valid way to renew. However, for the continuing education process, the change will be a movement away from 12 hours skills and 12 hours didactic to 20 hours of continuing education. So instead of 24 hours there will be 20 hours of continuing education in various topic areas that have been identified nationally and at the state level as being important. These topic areas are things like Airway, Resuscitation, Cardiac, OBGYN, Trauma Etc., instead of the trauma medical local option paradigm, these topics will be carved out into modules that can be taken either in person or online, depending on the module. The last two pieces of that recertification process in addition to the 20 hours of continuing education are to complete the annual protocol update, which is always been a requirement. The State will take over the enforcement of that, instead of turning it to the Jurisdictions to enforce. We will enforce it at least every three years when an EMT renews. The EMT will not be able to renew unless they can show that they have done the past three years of protocol updates. That said, the Jurisdictions should continue to keep track year to year whether their EMTs have done their protocol updates.

The component that has always been available and will remain available is the MIEMSS approved skills competency evaluation. Many of the jurisdictions send their people to MFRI and you can continue to do that to get the skills component, however, there will no longer be a 12-hour skills requirement. It is a MIEMSS approved Skills of Competency Evaluation that will take as long as it takes to assess skills competency. For example, if it takes one hour to assess an EMT's skills competency, than that is the amount of time it will take. Instead of holding people arbitrarily in the classroom for 12 hours to review and assess skills, we are going to recommend that skills competency evaluation take no more than two to two and a half hours. The ink is not dry on this regulation yet, but I wanted to present this information for questions or feedback.

Regarding early helicopter activation, I did share this with your PSAPS and this is something that was done once before many years ago Dr. Floccare put together a list of best practices for early helicopter activation. Essentially if you wish to do early helicopter activation, there was a guidance document that I worked on with the PSAP Directors that basically talks about where the value might be by EMD card. Therefore, if you are someone who thinks you might want to do early helicopter activation there is a very brief list that essentially goes over some of the EMD

cards to consider. This is not protocol; it is nothing more than a guidance document for the PSAPS and the Medical Director to discuss.

Bryan has a copy of the document that was formed in a PSAPS Director's group that MACO (Maryland Association of Counties) put together. Bryan feel free to share that it with anyone from the Council that would like a copy.

Bryan Ebling – Thank you, Dr. Chizmar. I hear clinicians speaking about early activations and there seems to be quite a variable process from self-dispatch to anything that sounds like a category A or B is being early activated. So one of the points that Dr. Chismar did not mention but it is in the document is that if you do an early activation and it turns out to be a category Charlie or Delta patient, you still have to do the consult in order to have the patient accepted by the Trauma Center. Did you want to add anything to that, Dr. Chizmar?

Dr. Chizmar – No, I think that covers it Bryan. The other part of the document that we discussed and the State Police have been vocal about as well is, if you happen to call them and for whatever reason call off the aviation mission they will convert those missions into training missions. They want you to know that if for instance, you get on scene, it is a Charlie, you consult, and it ends up not being a flight situation. They are okay with converting that into a training mission.

Jonathan Larsen – Dr. Chizmar, everything you said was a hundred percent spot on. There is definitely extreme value for the early activation in us, not wasting time allowing us to get to the patient side. Especially in the remote areas over here on the, lower Eastern Shore. However, in the event that it is determined that we are activated early and then maybe the patients not as sick as originally thought we could absolutely turn that mission into pilot training. Therefore, it is not just burned or wasted blade time on the aircraft. Our Pilots have monthly minimums that they have to go out and fly anyway, so if we just turn a mission that ends up being canceled into a training flight, it's just less blade time that we have to put on the aircraft at a later date and time.

Bryan Ebling – I think everyone knows that the Regional Coordinators are going out to the hospitals to observe and help educate how the Transfer of Care times should be documented in our EMEDS reports. I will turn it over to Michael for an overview of what we found in the hospitals that we have visited.

Michael Parsons – We actually polled all the counties in Region IV and for lower sure we did each department. I think we had feedback from everybody except for a couple individual departments out of Worcester County. It was interesting to see how each of the Jurisdictions and agencies are capturing the times. There is definitely many variables, some people are taking in their tablets, some clinicians are documenting by hand, some are calling into the 911 Center, and some of the counties' CAD systems are sending the data directly to Elite. There is a variation of when the clinicians are classifying the transfer of care. We have heard some people say that transfer of care is when a patient has been moved to the bed, not necessarily the transfer of care to the Nurse. We have actually been out to a couple hospitals and heard some feedback from some of the Nurses saying that EMS dropped off the patient and went down the hallway and

called transfer of care. The biggest thing is to try to get the correct information put in the data field and educate our EMS on what the exact time is we are looking for regarding transfer of care. I hope that having the flyers posted and continuing to do these hospital visits we will start seeing some improvement in the transfer of care time.

Bryan Ebling – I would like to congratulate the Salisbury Fire Department for meeting all of the requirements during their recent VAIP. We are working with the remainder of Wicomico County to get a couple of their stations updated. We are scheduling Ocean City for some time in December.

Hospital preparedness programs, there is an initiative called DRHMAG or the hospital preparedness program wants to get additional EMS participation in some of the planning activities that are underway. There is a Pediatric Surge exercise on January 23rd at TidalHealth from 10 AM to 2 PM. A Chemical Surge Annex exercise is targeted for March 7th in Queen Anne's County either at the Health Department or Chesapeake College. The Medical Response and Surge exercise is slated for April 23rd, but the location is not been identified. Most of those will have a virtual component; however, they do request in-person participation for anyone who is able to attend. In each case, they are asking for EMS participation.

Winterfest 2024 will be held February 2nd through February 5th. We are hoping the flyers will be out in the next couple of weeks.

Agency / Regional Reports:

Cecil County: No report.

Kent County: No report.

Queen Anne's County:

Zach Yerkie – I want to thank for all the Eastern Shore agencies that helped us out with the Bay Bridge Run. It was an extremely successful event and we could not have done it without all the support from our fellow EMSOPS on the shore. For those of you that participated and have not turned in an invoice yet, please do so. Outside of that, we are in a good place with our staffing. Our six transport units are pretty much in service every day and our third supervisor units are in service more often than not. We are starting to pilot and actually sent to Dr. Chizmar last week a pilot protocol submission for ANCEF for our IV pumps. I hope that we have good luck with that through PRC and get to start using that in the field.

Caroline County:

Kathy Jo Marvel – We just completed an interview process and we hired three more paramedics. Once they are cleared and on the street we will be fully staffed and have a float paramedic for one of our shifts. Our goal is to add one float paramedic per shift by FY25. Other than that, we are working on the MIH project and dealing with the bird flu. Luckily, it does not

seem like there is a human component to this and we already have all of the PPE on the units from Covid and flu season current so we are covered.

Talbot County:

Tina Kintop – We are increasing training on ultra sounds so that we can get all our providers up to speed. We are hiring, we are two ALS providers short so we will be having a hiring process at the end of the month.

Dorchester County:

Debbie Wheedleton – Not a whole lot going on. We are working on getting a few folks trained so that we can get them cleared and out on the street.

Wicomico County: No report.

Salisbury:

Chris Truitt – I am envious of all of you saying that you are fully staffed because we are not as usual. We have a few openings here and there we are just moving towards what Ocean City did a few years ago where it is just a continual hiring process and as we have openings, we will bring people off the list.

I am submitting our protocol submission for ultrasound in the very near future. I heard we have four applicants for the fire chief position. We were told by the city leadership that we would know by Christmas who our next fire chief will be.

Wicomico is participating in the Triennial Airport drill that will happen at the Salisbury Airport in March and we may be reaching out for some neighbors to help with that.

Worcester County: No report.

Ocean City:

Rich Koch – Nothing to report.

Somerset County: No report.

MSP/Aviation:

1st Sargent Larson – I do not have anything else to report. I just want to wish everyone Happy and blessed Thanksgiving.

TidalHealth:

Doug Walters – We are currently in the planning stages for our 2024 Trauma Conference. It will be the third Friday in September. If anyone has any interest in topics you would like to hear, or know of a speaker that you would like to hear, we are open to suggestions. Please reach out to Kathy Nichols, our Trauma Program Manager, or myself.

Union Hospital:

Falon Beck – Nothing to report.

SRH:

Lisa Lisle – I will go ahead and report for Easton, Queenstown, Chestertown, and Cambridge. Thanks to all of the Jurisdictions that took part in the MCI bus accident that occurred about a month ago. A lot of teamwork went into that with the reaching out to the hospitals and finding the appropriate destinations for those patients. So just kudos to everyone involved in that.

AGH:

Yelitza Hernandez – Thank you Dr. Chizmar for adding that EMS can call through the ER landline. I do not believe that has been a problem for our ESA folks. I think ESA, between PRMC and AGH has been fantastic about providing their names, however, I will certainly reach out to our local folks just to let them know that this is an option and share with them the direct line to the ER.

The only other thing I did want to mention is that we have brought several new nurses into the ER that are going through orientation. So to our EMS folks, just remember to be patient with some of those new nurses. We are going to be working with them on transfer of care times and things like that. Therefore, if you find yourself having these random questions by the nurse you are giving a report to, just be aware that they could be new and still learning the ED processes.

Health Departments: No report.

Old Business: None

New Business:

Chris Truitt – Just remember that eMEDS is transitioning to 3.5 on December 1st. Therefore, it is probably worthwhile to have somebody stay up or wake up around midnight because Jason is

going to be online walking through that. In addition, remind all your clinicians that they need to be out of eMEDS and do not start a report after 11:30pm on the 30th.

Dr. Chizmar – I know Jason has talked to a bunch of the billing companies, however, if you have not touched base with your billing company please reach out and make them aware. They should be relatively familiar with what it is we are doing since it is a national thing.

Bryan Ebling – What is the opinion on in-person vs. hybrid meetings going forward for the Council.

Chris Truitt – I will send something out to the Council to get a feel for what everyone thinks.

Adjournment: Motion to adjourn was made by Mary Alice Vanhoy; Seconded by Zach Yerkie and the meeting was adjourned at 3:06.