

CASAC Meeting
Minutes – May 15th, 2024



Meeting called to order by Chairman Rosenberg

Approval of minutes – the minutes from the March meeting were sent out by SOCALR.
Are there any additions or corrections to the minutes? None
Motion to approve: Jill Dannenfelser, Seconded by Jimmy Pixton.
No objections to the motion – minutes approved.

State Medical Director's Report – Dr. Chizmar

Dr. Chizmar acknowledged that Dr. Delbridge had joined our meeting today and asked if he would like to speak at the meeting. Dr. Delbridge declined.

Dr. Chizmar introduced Randy Linthicum, who has been around a long time, but announced Randy's new role at MIEMSS as the Deputy Director. Randy is doing a number of things and one of those items is covering the Office of Clinician Services. If there is a question that cannot be answered by Scott Legore or Scott Barquin, they can reach out to Randy Linthicum.

Protocol Review Committee – Dr. Tim Chizmar

We were lucky enough to receive 6 nominations for the Commercial ALS Representative position on the Protocol Review Committee and it was a tough choice among the candidates.

John Oliveira was chosen as the Commercial ALS Representative.

Jonathan Siegel was chosen as the Alternate.

Alternates are invited to attend all meetings, but only "vote" if the representative is absent.

We would like to thank them again. Thank you!

SCT Protocols – Dr. Tim Chizmar

This year there was a regulatory change and a protocol change.

The regulatory change we said if there is a single critical care intervention the SCT paramedic would be able to manage that call without having the second clinician or nurse on those calls.

Some questions have arisen. He would like to cover those questions and see if there were additional questions. All of these changes were brought through the STC Committee here at CASAC and were voted on by CASAC. He is trying to

provide some interpretation to close up any gaps. None of the following information is new.

Antibiotics/antifungals/antivirals have always been ALS (via OSP Protocol 15.4) for adults. We did not make any changes for pediatrics, so, if the antibiotic is the only critical care intervention, SP could run solo. He did send this to Dr. Anders and he is waiting to hear back from her regarding pediatric antibiotics so he will get back to the group on pediatrics.

Argatroban – Would be Specialty Care Paramedic if it is the only critical care intervention.

Atenolol and Propranolol – Same as Argatroban. Older Beta Blockers that people are not using much anymore, but these can go by Specialty Care Paramedic.

Banana bags – Can go by Specialty Care Paramedic.

FemoStops – There was a questions about FemoStops. These are a little different than TR Bands and those remained at the SCT level (or SCT/RN). We did not change anything.

Insulin – There was a question regarding insulin alone or within TPN or PPN. What we agreed to at CASAC Commercial level service is that anything with insulin that is not patient controlled would go by Nurse. If going by gravity, the TPN/PPN does not need SCT/RN. If it is running on an infusion pump and not patient controlled, TPN/PPN needs RN or trained ALS Clinician (paramedic oriented to SCT). Any insulin that's going by IV route, we made RN level (we removed the insulin in TPN/PPN). Those changes were made based on everyone's feedback over the past year.

Dr. Chizmar opened up the meeting for questions on these changes. There was one question in the Chat from Zach Risoldi "Is there a list available for the medications or interventions that were previously RN and are now moving to Specialty Care Paramedic? We would like to work on education for these items in advance." Dr. Chizmar advised the protocol is a document and people are still finding little inconsistencies and Meg Stein has been managing that change management group. Not a ton of changes, but he can provide a screenshot of that protocol page. He hopes to have that pdf posted on our website within the upcoming week. Meg is doing the last item which is the cover photo tomorrow. Dr. Chizmar shared the page "15.38 Optional Supplemental Protocol – Specialty Care Paramedic (continued)" during the meeting on the screen. He pointed out which items moved from one column to another regarding SPC and RN.

Regarding Heparin and IIb inhibitors, if the service has that OSP, it will remain ALS OSP. That's one correction that Meg is making to this table before we

publish it. Those did not automatically become critical care, but critical care above certain dose ranges.

Dr. Chizmar pointed out that a lot of medications and procedures moved from the RN column to the SP column and these should be reviewed.

A question came "As far as the ALS OSP for Antimicrobials, has anything changes for the language for the transfer to ICU?" Dr. Chizmar advised there have been no changes regarding the OSP for Antimicrobials this year. This was discussed this year with the CASAC SCT group, but it can be discussed in the future, if needed.

SCT Service – Dr. Tim Chizmar

Dr. Chizmar wanted to cover a "broad topic". He advised we defined the Specialty Critical Care services not only by the things you carry onboard, but also the people you have onboard. SCT services are handled differently around the country. Some places require complete protocols written for each service. We don't do that. But, what we do ask is for each service to submit their SCT medication list, and each of you do that every well. However, there is a lot of differences between the services and their list of SCT medication lists. Some are 3 pages and others are 6 medications over and above the ALS skill. It is not my business to tell you which individual medications you need to carry. In the interest of fairness and having a system-based approach to this, what we ask if that you have a least one medication from each of these broad categories. I wanted to bring this topic back to the group today for awareness. The only ones seeing these lists are myself, Scott, Marty, and Donna. You are not seeing the other services' lists. I want to be fair and I am open to questions on that. I don't think it's fair for one services to have a few medications and another to have 3 pages of medications. Dr. Chizmar asked for questions and was looking for a discussion. To start the conversation he questioned if is an unreasonable approach to ask the service to have a medication from each of the categories? Will Rosenberg spoke up and asked for others to speak up. Jimmy Pixton spoke up. Jimmy advised some services have their specialty care license but they don't transport the very serious patients. Especially if that service is surrounded by all the hospital based services. There some services that do much more advanced specialty care where others may not. Some services don't see many of the SCT service type transports. Other services may need more advanced medications based on their type of transports. In addition, some services have more advanced nurses traveling on their units. Jimmy stated there is a difference between the different individual licensed services. Dr. Chizmar advised there are two clarifying factors he would like to put in there is that SCT is one of the things we license by the services, not the truck. Nothing in this discussion today implies that every truck you have would need to have SCT medications. The second piece is that when Scott goes out to inspection, all he asks for is that the SCT medications are readily available in a bag or another available form. The

medications do not have to be physically located on the truck itself. If you are an SCT service we are just asking that you have one bag available with some of these major medications included and available. Will Rosenberg spoke up and said that he thinks the global issue is that when these SCT medication lists were rolled out in 2007 with Dr. Rau that the initial intent was different. It has changed over the years and we have varying degrees of SCT services at this time. Will pointed out that probably half the services have SCT licenses, but some of them are transporting with nurses. Fewer services are doing traditional inter-hospital critical care. The SCT medication lists will vary based on the actual type of care each service is providing with their trucks and clinicians. Dr. Chizmar said this information is helpful and he is not hearing a discussion to make a change. He just wanted to bring these differences forward for transparency sake.

Education – Dr. Tim Chizmar

Switching gears, Dr. Chizmar wanted to bring forward another topic that has been on everyone's mind and that is education. We had a regulation that was in its final phase and ready to go to the board for final approval. We are not going to take it back to the board for final approval. This concerns BLS renewals. We have gone back to the stakeholders, academies, and we are coming back to you to get your feedback on the BLS renewal process. We had been working towards making the BLS renewal process a little bit like the paramedic renewal process. We were trying to make the topics timelier, such as topics that appear in NCCP model and that appear in QA/QI. We still endeavor to do that. We still are working towards modernizing the EMT renewal process. We want to get away from calling it an "EMT Refresher". We want to move it towards "EMT Renewal". What we initially proposed was 20 hours of continuing education. Based on the feedback we have had from other stakeholder groups, we have heard that comes at the expense of taking away knowing if the EMTs are proficient with their skills. We had left that last 4 hours up to doing protocol updates and doing a skills proficiency check off. What we have learned through a variety of educational programs is that the remaining time was not sufficient to cover skills. We have had sufficient issues with many EMTs that are out there actively practicing doing basic skills that we expect them to do. What I propose back to the group is that we allocate more time back to the skills portion of an EMT renewal. Initially it was 20 hours didactic, leaving 4 hours at the end. What I think we probably need to be closer to is about 8 or 9 hours of skills, based on what the educators statewide have indicated. That what it takes them to bring exciting EMTs in and assure their skills are up-to-date. We have heard from the education community. I would like to bring it up to the group. Right now, but not written down, is 15 hours of didactic education and 9 hours devoted to skills proficiency. Dr. Chizmar would like to hear from the group about their thoughts. Danny Platt from Lifestar and Keystone spoke up. The question he has is that if programs think they don't have enough time to do skills, why don't they add more skills into their programs instead of changing the entire state's program? What we have heard is that the most common place where EMTs are checked off on skills is within Commercial

Services and a few jurisdictions, using the existing reg to check them off. But what we have seen is that we can try to check people off, however, they would fail miserably. It takes a lot of remedial time to get them back up to speed. Basically, re-learn the skill every 3 years because the skills are not frequently used skills. I think if we put it out there as 24 hours to cover these topics without any attention to didactic or practical skills, people may do everything online. We want to make this online friendly as we can, but if we don't dedicate some time to hands on skills people will have a tough time completing basic skills. Dr. Chizmar is not sure what the commercial services are doing to check off clinicians, but he asked if they are having to spend time re-educating the clinicians, or working with them to getting their skills up-to-date? Danny mentioned that in our field, the clinicians are not using a tons of skills. The skills that they use, they are proficient with the skill. Some of the other skills, they are not. We are adjust to those skills and add more hours. Danny questioned the motivation behind adding additional hours to teach skills that are rarely used. Dr. Chizmar mentioned that what we observed by watching two pilot classes were that people could not do essential BLS skills. Dr. Chizmar mentioned several examples of skills that the EMTs were unable to complete correctly. Dr. Chizmar was surprised and that we found out that the basic skills that we may assume our people have, they don't. That creates the motivation for more time dedicated to skills. Jimmy Pixton spoke up and advised he just called their instructor. He advised they do skills once every 2 months. The instructor did say that their splinting is the worst. He said they are usually fine once they are shown the skill and he refreshes their memory of the skill. Jimmy said he was sharing to give Dr. Chizmar a prospective since they are one of the bigger companies. Dr. Chizmar appreciates their prospective. He wants to be clear that we want to capture all perspectives. This is not something we are going to write down and send to SEMSAC and the board tomorrow, but we are going to let that regulation we had out their just lie, not act on it, and commit ourselves to writing a new regulation over the next few months. Dr. Chizmar asked if Scott Legore could capture feedback. Dr. Chizmar wanted to introduce the topic. Will Rosenberg spoke up "I wonder if all of our EMS people, probably 98% of them, working in commercial services are actively taking care of patients?" When you look at MFRI and the County Academies, how many of those people that hold an active EMT card and work for a 911 service, are actively on practicing on an ambulance? I wonder if this is part of the problem." Will went on to point out that we, commercial services, may have more practicing clinicians than those clinicians that are certified and that are being evaluated every 3 years by these training institutions. Dr. Chizmar stated that he understood what Will was saying, but he does not have the data to support or refute that idea. That is a good point. We are in this "re-build" mode and everyone's feedback is important. Dr. Chizmar advised there has been a lot of questions about how EMT renew and that regulation is not going to go into effect as we originally intended it. Some portions of that regulation were the dates, moving the renewal dates by one month, so part of the regulation changed and some parts are not moving forward. That's the big announcement at this time so the group is not wondering what is going on. Scott

Legore asked that if any other service had thoughts, concerns, or comments, to please forward to him and he will get them to Dr. Chizmar.

SCT Equipment – Dr. Tim Chizmar

Dr. Chizmar advised he didn't have that document with him to discuss SCT Equipment, but maybe Scott Legore does. Scott said in light of the SCT regulation change, the question came up that since we are now allowing solo paramedic on SCT transports... If a solo paramedic does the transport, do they need to carry the entire SCT equipment list? Some of the items on the list are specific for nurses and stuff needed outside the scope of the SCT paramedic. Even the quantities are outside the scope of the SCT paramedic, like requiring 4 IV pumps when an SCT paramedic can only monitor one if they are solo. Scott said he is going to turn this back to the services and ask for their recommendations for changes to the list. Once we get some recommendations, then we can run it by Dr. Chizmar and we can come up with a solo SCT paramedic equipment list. We would still need to come out and inspect the entire SCT equipment list as part of your service's inspection, but when that truck is operating as a solo SCT paramedic we could have a modified list. Will spoke up and advised he brought this question to Dr. Chizmar. Will advised the group that Dr. Chizmar and Scott Legore were looking for the group to kick back a list of SCT equipment that should be on that modified list. Dr. Chizmar mentioned that one challenge we have is that we don't want to end up with situations in which a nurse is needed, but the service doesn't have the necessary equipment onboard to make the transport. Will opened the floor up for the critical care services to share their thoughts. Danny Platt, Lifestar & Keystone, advised he would suggest that they have an ALS/SCT paramedic bag and a nurse's level bag. The nurse would keep their bag with them. Zach Risoldi, from Pulse, said they would echo that idea and would be happy to provide their SCT with a SCT bag and our nurses would carry their own equipment separately. Jimmy Pixton, AAA, stated that they concur. That's how they do it. The nurse has their own equipment. The paramedics do not carry around the nurse's equipment. The nurse manages their own equipment and maintain it. Dr. Chizmar spoke up and indicated that if a service didn't want to have two different types of bags, they could have one bag which also contained the nurse's equipment. Dr. Chizmar feels we would be fine with that bag. Zach asked if this would be a regulatory change. Would this take place before the July 1st date? Scott said he does not feel this needs to be a regulatory change. We would have to run it through Claire Pierson's office. Dr. Chizmar stated that there are only a couple of placed in COMAR that specify a whole ton of equipment. He thinks one of them is in the area of transporting obstetric patients. We would need to discuss with Claire and get back to everyone. Claire Pierson said she doesn't know the answer at this time, but she thinks the list could be handled by SOCALR outside of regulation. She will take a look. Will suggested that several of the members (Zach, Jimmy, Danny, and himself) can circulate information between themselves and come up with an

agreed upon list and send to Scott. Zach and Jimmy both agreed to this suggestion.

SOCALR Report

Inspection/License Update – Scott Legore

Inspections: May inspections are in progress. June renewal packages are going out.

Using updated forms – Some services have saved the forms to their computers and are using outdated form. We have been updating our forms. The most current version of the forms can be located on the MIEMSS website and the Services' Dashboard.

Drop Vehicles – Removing logos and control numbers.
Per the COMAR regulations, when a unit is dropped, the MIEMSS decal and control number needs to be removed. We are asking that the services do that and that step has been added to the drop vehicle form.

Yearly MSI Requirements – Scott Legore

30.09.07.03 E and Education Article 13-515 c (2) (iii)

There has been some discussion regarding the requirements for MSIs yearly, specially related to the first year of a truck and the certificate of origin. The regulations are pretty clear and they spell out that you have to have yearly Maryland State inspections. It's not only covered in the regulations, but also covered in the Education Article. We allow the certificate of origin to qualify for a year. The issue that seems to be coming up is that the manufactures are taking longer than a year to get the truck to the services. Therefore, when you get a new truck we are requiring a MSI before you put it on the street. I understand the concern. The regulation is clear. We have had some discussions with Claire and it is spelled out not only in the regulations, but also in the education article. At this point we are holding to that the certificate of origin is good for a year from the date the truck is manufactured, not the date the truck was sold to the service. From that point the truck will require a MSI. I understand that is creating so undo costs, but that is the way the regulation is written. Jimmy Pixton asked "What is it that we have to do to fix this? Common sense has to... there are cases where you would require a vehicle with 10 miles on it to be inspected. What is it that we have to do?" Jimmy went on to say that was never the intention when we wrote that reg. It was pretty much if it was under a year old it would be good until one year. We use to use the purchase date. So it wasn't until recently you started going by the certificate of origin, which in some cases these ambulances are at the factory. He said it happened to him and both of his units were less than a year. He didn't understand. He thought it should have gone by our inspection day, the first day they used the unit, or the purchase date. He feels to go by the

certificate origin doesn't make much sense. A new vehicle in Maryland does not require a motor vehicle inspection. Again, Jimmy asked how we change it. Scott advised we would have to introduce a regulatory change. Jimmy stated that he thinks that is what we all want because this keeps coming up. Will Rosenberg spoke up and stated that he agrees with Mr. Pixton. He feels SOCALR is following the regulation, but not the intent. Claire Pierson advised that SOCALR should follow the regulation. We could investigate a regulatory change if SOCALR was interested, but we cannot conflict with the language of the statute. Claire said that she could look at the language between the language of the statute and the regulation. If there needs to be a change, there would need to be a statutory change. Scott said that the little bit of research that he has been able to do, it is not only in our regulations, but is also in the education article. It addresses the yearly MSI requirement for all commercial vehicles. Jimmy said that he is being somewhat clear that is what we want to do. We want to change it. Scott advised that he understood. He will get a process and send it out to everybody. Jimmy advised that was originally written in 1992, back when it only took a couple of months to get an ambulance. Now when you buy an ambulance the certificate of origin might be two years and this is going to continue to come up. Ambulances are backed up at the manufacturer and this will continue to be a problem. The services are going to have to get the ambulances inspected before the service gets to use them. The ambulances are arriving with an average of 10 miles on them. His service plans to purchase 8 or so ambulances this year and the MSIs are going to be an expense. Scott repeated that he will get some information out as to what needs to be completed to start the process. Jimmy stated that he feels the inspection should be based on the purchase date or we could put mileage on the regulation, like under 1,000 miles. Something to the effect that the unit was recently purchased and under 1,000 miles would solve the problem. It would be a year from the purchase date. Scott asked for any other comments from the group. No other comments were made.

QA Review/Data Imports – Scott Legore

Scott Barquin is sending out emails with monthly reports for missing clinician numbers or unidentified clinicians. You should be getting reports around the first part of the month with a list of your clinicians from the previous month. You should work with him to identify them and re-upload the reports once the clinician numbers are corrected. There was an issue when Traumasoft did an upgrade and clinician numbers changed. Scott thinks that all, but one or two services, have fixed this situation. Just a reminder, if you need to upload a lot of reports, please do it during the evening hours or overnight so you don't overload the system.

One thing we tried to do last month was that we looked at the numbers that the services were submitting on their Monthly Data Reports and compared those to the eMeds reports that were imported. We reached out to a couple of services where the numbers were off sufficiently and we are working with them to try to

identify why. One of the things that came up (and we are not taking any action at this time) was that the way the Maryland regulations are written is that it covers transport to, from, and within the state. So if the transport starts outside the state and comes into Maryland, or starts in Maryland and goes to an outside hospital, or it is inside the state the transports all fall under COMAR regulations. With that being said those reports should be uploaded to our system because they fall under COMAR. My understanding is that a lot of services are not doing that for the calls that originate out-of-state. It is something we are looking at internally to make sure we are not crossing any paths. We are not making any changes right now, but it may be something we may have to look into changing in the future due to the way the regulations are written. Jimmy asked where is that referenced in COMAR. It is in 30.09.08.A3, 30.09.08.A6, and 30.03.04.04. It is located in 3 different sections in which it speaks about transports and what has to be uploaded. Will stated that Maryland does not report this data to the feds. So why are we tasking human and technological resources to report data to us, that we don't even upload to the feds? Scott advised we use the reports internally. Scott had a talk with William in reference to NEMSIS. NEMSIS data is basically for 911 services and our agreement with NEMSIS is that we filter out the commercial services' data. We do not upload the commercial services' data to NEMSIS. Will pointed out that we are unique as compared with other states in that regard. Scott said he believes we are one of the few states that has the ability to filter it out because of the way our state system is set up. Scott spoke with William and Claire and it has been that way since we set up our state system. Will spoke to Jimmy and others that they could end up sending duplicate data when coming from DC and other states. Will advised NEMSIS only wants the data from the origination, not the termination. Jimmy pointed out that we are only requiring that information because they are licensed in Maryland. So, he asked, if he has a truck exclusively licensed in DC, the crew is DC only, and they go to a MD facility, we are requiring him to let us know that only because they are licensed in MD too? Scott said he believes the answer to that question is yes. Scott said he is not following Jimmy's train of thought because the out of state services that do MD transports are required to have an exemption through SOCALR and report their data to SOCALR as well. Scott advised the regulations allow an exemption for an out of state transport, but they have to be approved by SOCALR and we track those transports. Will pointed out this situation occurred 3 years ago and SOCALR sent out Cease and Desist letters, but that SOCALR had no enforcement teeth to enforce it. Scott pointed out that SOCALR has very little enforcement teeth for any unlicensed service. We do send them Cease & Desist letters. Will stated, like Jimmy mentioned, when it is out of state, those services don't have to send SOCALR any data. Scott said that he would disagree, but with licensed services it is a different situation. Jimmy said he doesn't care about sharing the data, but that the services have to give Traumasoft some line to draw as to who gets the data and where it goes. Jimmy said he would have to work it out with Traumasoft and see if we can duplicate the calls. Jimmy said one of his concerns was that they would be duplicating NEMSIS data, but since SOCALR doesn't report, it would not matter. Scott said from NEMSIS standpoint that is

correct. It would not be a duplicate of data. He said SOCALR is looking for the data to meet the regulatory requirement. Teddy Baldwin asked how it works when the reports are submitted from DC crews and now there are clinician numbers missing because they are not MD licensed. Jimmy pointed out there are a lot of clinicians in the situation. Scott said he understood there is going to be some logistical issues that would need to be worked out. He is just throwing this information out there as to how the regulations read. In speaking with Claire, she thought we had some time to try to identify how we were going to address this. He wanted to put this information out to the group because he has already talked with several services and there were some questions about it. This is what the regulations say. We are not jumping for immediate change. Scott does not have an answer for Teddy at this time. Scott feels that if we really went by the letter of the regulations, that crew would have to be MD licensed. Because the service is licensed in MD, that crew comes into MD, therefore they would have to meet the regulatory requirements. That may not have been the way it was done in the past. Teddy pointed out the crew is not picking up in MD. Jimmy wanted to know what the motivation is behind this. Jimmy wanted to know if the numbers help with funding. Why would SOCALR care that a DC resident was brought into a MD nursing home, just over the line, by a DC crew? What is the reason that SOCALR would need that information and that it is that important? What brought this up? Scott advised there is no motivation what so ever. This all came up when we started developing a better way to collect the data and we are identifying issues that have been long standing issues. These issues probably have never been identified before. That's bad in some ways, but this issue has been out there. Scott had never compared the number of transports that the services are reporting on a monthly basis with the number of reports that show up in eMeds. To the best of Scott's knowledge, that has never been done. The old system did not allow it. Now he can click on the computer and see how many reports any service does, can filter out items, and compare the numbers with eMeds. He did it. There are glaring discrepancies. He is looking to correct them. SOCALR is self-funded from the services. This is not a funding issue. There was additional discussion regarding transports in, out, and within the State of MD and the interpretation of the regulations. Danny Platt advised it would be impossible to enforce. Claire said the regulations in regards to data covers every transport to, from, and within MD and the regulations are very clear the way they are written. It states that the data has to be reported to MD if there is a transport into MD. Claire said she was not aware that it would cause an issue with the clinician's licensing. She will have to look at that. There is no ambiguity with the data reporting requirements. Zach Risoldi asked if commercial services data is not being reported to the NEMSIS at the federal level, what the obligation for the services to remain NEMSIS compliant? Scott advised it integrates with our system. Scott had to go back and look into this information. When they originally went to do the data imports the original proposal was to have the entire MD data set. But a lot of commercial services do not use the eMeds reporting so the compromise was to use NEMSIS data, which our system accepts. The only fields that we require outside of NEMSIS is the destination code and clinician ID

numbers. They have to be specific to the MD data set. Scott is referring to commercial services requirements, not the 911 data entries. Will asked Claire if it only pertains to reporting, not to vehicle or provider licensing. Claire said off the top of her head she doesn't know if vehicle or provider licensing. She thinks it does, but she will have to look into this further. Scott mentioned that they, Claire and himself, only looked at the data portion of the regulations when they were looking. They did not look into these other items. Claire will do some research and let the group know what she finds out. Scott mentioned again that we just identified this and we are not looking for anybody to make changes at this time. He wanted to mention it to the group so that we are transparent. We are trying to figure out exactly what we are going to do with this to ensure that we are all compliant with the regulations. Justin, from Traumasoft, spoke up. He wanted to make sure that he heard a couple of the items correctly. He asked if a Virginia licensed services transports into the State of Maryland, we expect that service to make a report to MIEMSS? Is that correct? Scott advised an out of state service that is not licensed in the State of Maryland does not have to submit their ePCR, but they submit their transport numbers and they have to be an exempt service with the State of Maryland. The service would have to have a State of MD license or have an exemption on file with the State of Maryland. Zach mentioned this is referenced with the Air Services category with fixed wing services that come into the state less than 20 times a year. Is something like that practical for the local services doing the same thing? Scott said the exemption category has two separate lines. One is for ground services and one is for air services. Zach is correct, the air services has a specific number that it allows before they have to be licensed. Will advised we will defer this topic to Claire and Scott to do a little more research on their own part before this group makes a recommendation to MIEMSS. As it was presented, it is not palpable for all the services that are multi-state licensed, including the District. This information and/or changes will present challenges for the multi-state services. Scott said he understood and wanted to make the group aware that it is being looked into and be completely transparent. Justin from Traumasoft advised he would be interested in attending any follow up discussions on this topic as he works with a number of services that are not Maryland based, but transport into MD. Scott agreed to include Justin. Justin mentioned that he is not in the game anymore, but his opinion is that it may be better to change the regulation than to try to enforce the existing regulation. He mentioned that the regulations still reference the MAIS forms, so maybe it is time to update the regulations.

Equipment Update - Scott Legore

2024 ERG is out. Scott is not looking for the services to go out and purchase the new ERG tomorrow, but the services should be looking to purchase them and get them on the trucks. If you have the electronic version, you should be downloading the new 2024 version.

Go To Connect – SOCALR has moved to a Go To Connect voice over internet phone system. We are currently in the test phase. It gives all of our inspectors the ability to make and take phone calls without using their personal phones. It also gives SOCALR the ability to have voice mail separate from our personal cell phones. We haven't made a full scale change over, but you may see us putting a new phone number out there. Also, the fax number we have internally is no longer working due to the steam line rupture that occurred a while ago. All the fax lines were damaged and they have not been repaired. We do not have a time frame for those repairs.

Smartsheet Updates – Reminder that the Smartsheet dashboards are up and running. We have updated them to include the medical review committee and upcoming inspections to each service's dashboard.

Non EMS Driver Waiver – Just a reminder to all of the services that have the Non EMS Driver Waiver, you must submit your new drivers to be approved prior to them driving. We have issued 3 non-compliant notices over the last 3 months for services that have had drivers operating prior to being approved. Please ensure your drivers are approved prior to driving.

Clinician Services – Randy Linthicum – No report.

Scott Legore reminded the services that Scott Barquin is your go-to person within SOCALR for any problems you may be having. He is only looking at clinicians with commercial services. If you have a licensing issue, feel free to reach out to him.

Dr. Chizmar spoke up and advised Randy is on the road. The only business Randy wanted to cover was the educational portion that Dr. Chizmar discussed earlier.

A question was asked if the licensure portal problems were going to be fixed and resolved. Scott Legore said he looked into this situation and that he has learned that this is an Imagetrend problem and they have a trouble ticket submitted. We are waiting on Imagetrend to troubleshoot the problem and correct it. It is not an internal MIEMSS problem or a personnel problem. It is a software problem that we are trying to solve with Imagetrend. Dr. Chizmar confirmed that this is the situation and they have list for Imagetrend.

Committee Reports

PEMAC Report – Jill Dannenselser

New protocols are out and they are working on an app for the new protocols.

Also, if you have any pediatric protocols you would like changed for the next round of protocol changes, please submit that information to Dr. Anders by July 3rd.

SEMSAC Report – Danny Platt – No report.

MIH Report – Mark Buchhotlz (Not available) – No report.

Old Business – Scott Legore

SCT Regulation Changes – Status

The SCT regulation changes have been approved by the EMS Board. They are out for final publication. The plan is for them to go into effect July 1st

Non EMS Driver Regulation Changes – Revision

These regulation changes were approved by SEMSAC at the last meeting and they have had their first reading at in April. They did not have a meeting in May so the second reading and the vote will take place at their June meeting.

New Business - None

For the Good of the Committee - None

Adjournment

Motion to adjourn by Jimmy Pixton, seconded by Matt Larrabee. Meeting adjourned 14:14 hours.

Attendance:

In Person: Scott Legore, Will Rosenberg, Donna Geisel.

Virtual: Dr. Tim Chizmar, Dr. Delbridge, Jimmy Pixton, Brad Kuch, Danny Platt, Jill Dannenfelser, Tyler Stroh, Zach Rosoldi, Barbara Goff, Claire Pierson, Jimmy Harsh, John Roussis, Jonathan Siegel, Justin Gebhard-Kram, Justin Webster, Katie Sinclair, Lindsey Leach, Leigha McGuin, Matt Larrabee, Rob Weiss, Teddy Baldwin, Todd Abramovitz.

Callers: #1 – John Damiani
#2 – Kevin Barnes
#3 – Mike Moretti
#4 – Justin Kinsey, TraumaSoft
#5 – Kevin Barnes
#6 – Will Rosenberg

