CASAC Meeting
Minutes – May 21st, 2025

Meeting called to order by Chairman Rosenberg

Will Rosenberg: Welcome to the May CASAC meeting. First and foremost, Happy EMS week to all of you.

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: Tyler Stroh, Seconded by John Oliveira.
No objections to the motion – minutes approved.

Will Rosenberg: All right. Hearing no objections the minutes are entered as approved. Dr. Chizmar, our State EMS Medical Report.

State Medical Director's Report – Dr. Tim Chizmar

Dr. Chizmar: Good afternoon, everybody. As Chairman Rosenberg said, Happy EMS week to everyone, and a sincere thanks for everything that you do day in and day out. I know that a week is not enough to appropriately thank you for that, but I want to.

Dr. Chizmar: The couple of med issues, just to be aware of, is there is a known shortage of amiodarone. We don't know exactly how long that will last. But if you're experiencing that amiodarone shortage, I know at least one or two services have reached out to Scott and we can provide a waiver to switch over to lidocaine for the short-term future. The protocol essentially is very close to what it used to be prior to us putting the amiodarone in place and it's posted on the website. You do need to make that switch over; the protocol is up online. We just ask that you let Scott know and secure the waiver before ordering or using lidocaine for that purpose. If you're wondering, we're not using an inferior drug. There have been studies since we've made the switch over to amiodarone that basically say that lidocaine and amiodarone are relatively equivalent in terms of their efficacy. I think that's pretty much all I wanted to cover on that.
The other thing that we're hearing may be coming is a shortage on advantage Diltiazem. One of the two manufacturers is talking about stopping production at the end of this year. We are looking at it through the protocol review committee with everybody at the table. Looking at either Esmolol or metoprolol and getting rid of verapamil. Verapamil is an old crummy drug that causes a fair amount of hypotension. Unfortunately. We must sort of reconfigure ourselves and these shortages happen So we're trying to stay ahead of that one since we have a little bit of advanced notice. The alternative, of course, is using Diltiazem vials, or if you happen to be one of the lucky ones who is ordering from the manufacturer that will still make advantage Diltiazem, then you'd have that available to you as well. So more to follow, that's an end of the year problem, but just wanted to make you aware ahead of time.

Dr Chizmar: Concerning this year, the protocols for 2025, July 1, 2025, have been completed. They're up online in PDF format. The spiral books are available for sale at the office for $10. There's no price change. As you recall, we're not doing the pockets. We haven't done the pockets for over two years now. But the app will be updated. I don't have a date on the exact update, date for the push to Apple iOS and Samsung yet. Or iOS, I should say. I'm sorry. What am I trying to say? I'm obviously an iOS guy, Android, that was the word I was looking for, having a little TIA there, but we will push an update in the very near future. The video update portion is in its final phases of editing. I should have that back to Melissa by today, and we should be able to post that on the online training center within the next few days to give everybody a solid five, six weeks or more to do that. As you all recall from the meetings throughout the year, it is relatively ALS-heavy because we added Cefazolin, we added Labetalol, so there were some additions on the ALS formulary side of things.

Dr. Chizmar: We spoke about the other piece that affects commercial service video laryngoscopy. The board agreed to let that be a phase in and not take effect right away until July 1 of 2026 to allow people time to prepare and procure various devices. So long story short, the video updates should be posted very shortly. There will be an official announcement that goes out through the GovDelivery system to that effect as well. Apart from that, I'm not sure if Aaron's on the call. Again, I'm joining you from the road. He may want to go into this in greater depth.

Dr. Chizmar: Our licensure regulations, EMT renewal regulations, are going into effect for the next research cycle. Those, you'll probably remember the ones where we trimmed down a little bit of the required skills in-person portion in favor of a little bit more didactic continuing education to make it look more like ALS. So for this research cycle, the people that are actively recertifying before July 31st, 2025, i.e. within the next two months, there's no change. After that, so the next EMT renewal date would be January 31st of 2026. That would be the first cycle of people, EMTs, that would be under that new renewal structure. With that said, working with Aaron and Dr. Delbridge, we're going to crosswalk continuing education that was done in advance of that July 31st state as much as possible so that people are, our goal is not to have people do extra work just because of the changeover and the cutover with changing up the EMT renewal. Once we get there though, I think this will be a far better, far more comprehensive review of relevant areas and not just sort of taking the same old CPR or PHTLS class over and over and over again, especially in the areas of pediatrics and obstetrics where we know that We definitely have a little bit of room to expand our knowledge base and what we can do assessment-wise for patients. Other than that, I'm going to try to look at the participant list here and just see if anybody else is on that should cover this in more detail. It doesn't look like it.

Dr. Chizmar: The emergency department advisory system is sort of one of the next big steps. The chat system is staying online for now. The emergency department advisory system is the rating scale of 1 through 4 instead of replaces the red and yellow with a rating of how busy the hospital is 1 through 4. I know that this doesn't impact commercial services entirely on a daily basis, but it's still worth knowing about. The test site is up online currently. It is test data. It is not live data. Just want to emphasize that again. It's EDAS, as in Emergency Department Advisory System, edas.miemss.org. For a while, the hospitals will probably feed data into both

systems and then will retire chats ideally within the next month. This will, it's again, hope that will give us a little bit more of an objective measure and try to load balance between the hospitals that are more available as opposed to less available. So that's something else you may hear out there. We've not made a formal announcement to the 911 services. Again, we're just in the phase where we're trying to get the hospitals online and familiar with the new system, get them logins, and so forth.

Dr. Chizmar: Chairman Rosenberg, that's all I had formally. I'm happy to take questions or if you missed anything because of audio, I'm certainly happy to repeat if you need to.

Will Rosenberg: Anyone have anything for Dr. Chizmar? I did notice two people have their hand raised. I'm not sure if that was from the previous motion or not, but note that because we're controlling from my computer, I can't put your hand down. So, if you don't need it, please put your hand down. And likewise, anything for Dr. Chizmar? Yes. Go ahead, Jimmy.

Jim Pixton: So we celebrated our 35th year in March, and I wanted to let you know we've never used charcoal. Can we do something about getting rid of charcoal? That's been brought up quite a bit in some circles.

Dr. Chizmar: It's a good question, Jimmy. I think, we can open to the discussion. I think if you're doing a 911 contract or, kind of serving in that role, we probably would need to. Keep it, but if you're confident, you're not doing any 911 work we can look at that.

Jim Pixton: Well, that was brought up. So, we would agree that for special events and things like that, we would do it. But to have it on every truck, it's becoming very difficult to get.

Dr. Chizmar: Yeah, I know historically what Dr. Alcorda handed off to me was just that, Jimmy. There's the standby component, there's the component where there are 911 contracts, and then there's a component where the commercial services play a valuable role in disaster type situations, which knock on wood, we hope we don't have. But I'm a realistic guy. I think we would just need to work with Scott as to how we would make sure that's done in transparent way. I certainly understand your perspective, Jimmy. I'm not arguing for charcoal for IFT services, but those nuances, I think we'd have to work with Scott and figure out how we can be fair and transparent with that.
Scott, I don't know if you want to chime in there at all or is Scott in the room?
I think he's off camera.

Will Rosenberg: No, he's in the room. I think he's going to try to chime in from his phone here. Hold on.

Scott Legore: I'm open to suggestions.

Dr. Chizmar: Jimmy, I would much rather you honestly, and not just you, but the other services as well, invest in things that are going to get used, but it's not lost to me that we don't know whether we need something until the proverbial, you know what,

hit's the fan too. Let's take it offline with Scott. Yeah, that's okay.

Will Rosenberg: Anyone else have anything for Dr. Chizmar?

Dr. Chizmar: I think you still have a hand up, let's see.

Will Rosenberg: I do, Brad. I get a little chat here from Justin Kinsey. It says, perhaps standby one bag can be thrown on a truck like an SCT bag.

Dr. Chizmar: It's one way forward.

Brad Kuch: Sorry, that was just approving the minutes. I took my hand down. I apologize.

Will Rosenberg: Don't apologize. It's not your fault that IT here is having some challenges.

Dr. Chizmar: You know, I think it would just involve a little bit of reconfiguration on the inspection side of things. But, you know, I wouldn't take it off the table, I guess, is what I would say for today.

Will Rosenberg: Thank you, sir. Anyone else for Dr. Chizmar? All right. Hearing nothing else we'll let him go hand out some more awards as he traverses the state. And we'll move on to the SOCALR report.

SOCALR Report – Scott Legore

Inspection/License/Renewal Update – Scott Legore

Scott Legore: The inspection license update, all the May ground services are done. We're currently scheduling the Air Services for renewal.
On the random inspection front, through May 1st, we did 26 random inspections. Eleven of those units had deficiencies, comes in at 42%.
Four of those were unsecured items. Four were expired medications or equipment. Two lacked the proper equipment, and one had a non-affiliated clinician.

QA Review/Data Import – Scott Legore

Scott Legore: Scott Barquin continues to work with the services on their data import.

Equipment Update - Scott Legore

Scott Legore: Then under equipment update, we sent out the July 2025 equipment checklist. BLS, SCT, and Neonatal remain the same. And then the changes were to the ALS checklist, we added labetalol, 100mg, increased dexamethasone to 15mg, both to work with the July protocols. Then we removed some language just to clean up the checklist. So, under the NDT, removed commercial flutter valve, which is an option in the protocols and has been for a while. I'm not sure how it got onto the checklist. Under fentanyl, we removed the line that said, “or morphine sulfate”. Since we've moved to fentanyl now, morphine is no longer a substitute unless you request it. And

then under the IV infusion pump, we removed the language that said "with approved LHPs" because we do not require LHPs for commercial services for the IV infusion pump. And then, I sent out information earlier this week, if you purchase 2025 Broslow tapes, there are errors on them. You should have been contacted by the manufacturer. Just so you're aware, there's a wrong concentration of sodium bicarb on one of the pages, and another page has wrong energy settings for defibrillation. That's all I have for our report.

Will Rosenberg: Thank you, Scott. All right, anyone have anything for SOCALR?

Tyler Stroh: Yes, I have. A question on the equipment list.

Will Rosenberg: Okay, Tyler.

Tyler Stroh: On the equipment list under Dextrose, it says D10. Is this the preferred? And it requires a minimum of 500 ml, which is two times, you know, two patients, right? We need 250 for one patient, but if we carry D50, we only need one. I was curious if there was a reason for that.

Scott Legore: I'm going to let Dr. Chizmar talk on that, if he's still on.

Dr. Chizmar: Sorry, I'm again on the move. What was the question?

Will Rosenberg: Short question was the way that the equipment list is, when you've used D10, you have enough for two patients, but D50 is one patient.
Why is it that there are 500 ml required for D10, which is a double administration versus D50, which is a single administration?

Dr. Chizmar: I don't know. I guess off the top of my head, the overall quantity probably did not get revised when we put D10 in as the standard front-runner.
Tyler you're suggesting we could you know knock one D50 off? I don't think that's unreasonable.

Tyler Stroh: No, but knock one D10 off, right? We typically, the requirements are enough for one patient on everything, but on that we have two.

Dr. Chizmar: We have two of D10?

Tyler Stroh: Yeah, it says 500 ml required.

Dr. Chizmar: And you're not counting the, so one of the things that I know Scott's run into with inspections, you're not counting the D5W, right? You're counting true D10.

Tyler Stroh: Yep, that's what it says on the list. It says D10 solution a minimum 500 ml.

Dr. Chizmar: Yeah, I mean I think we I think we can move on that. Scott, let's pin that so we can see if we can make that correction there. I thought what was going to go was the D5W, which some people use as diluents for different things. So sorry, I was

no.

Tyler Stroh: That's okay. So, our diluting stuff is, you know, is listed usually under the SCT stuff, set as a separate section.

Dr. Chizmar: You still have that for ALS, for some of the drugs and treatment, in there.

Tyler Stroh: Oh, right, right, right, right.

Dr. Chizmar: Scott, can you mark that so we don't lose that.

Will Rosenberg: He's shaking his head and promises a new equipment list coming out shortly for.

Tyler, Stroh: That's all I got. Thank you.

Will Rosenberg: Thank you, Tyler. Anyone else have anything for SOCALR?

Scott Barquin: Hey, Will, I have a couple things if you got a second.

Will Rosenberg: Fire away, sir.

Scott Barquin: So, thank you, everybody, for making the great effort to get all the destination codes into your patient care reports. We're making great progress. On the same note, I'm happy to report that a lot of the air services are going further and further out, so I've tried to get those facilities into the destination list as well. They are currently under review for the NEMSIS to put them up in the schematron, but those hospitals include: West Virginia University Medicine Children's, UPMC in Pittsburgh, Winchester in West Virginia, Penn State Children's Hospital in Hershey, VCU in Richmond, Thomas Jefferson in Philadelphia. So, we have a lot of the bigger hospitals out there that are now going to be included. When that becomes totally official and approved by NEMSIS I will send out an email and ask you to contact your Traumasoft or whoever you use and have them update the schematron for Maryland. One other request that we're receiving quite a bit is about services that transport to University of Maryland. There is getting to be a little bit of confusion on the hospital hub as to where that patient is going, whether they're going to University of Maryland or shock trauma. Shock trauma keeps sending me requests for quite a few patient care reports that are in their system but they are being transported to trauma so if you can make sure that the either the dispatch or crews put in the proper destination whether it be shock trauma or 634c would be very much appreciated and that's all I have oh one other reminder about affiliations all service directors have the ability to remove affiliations from their list. One of the very common statements I get is that that person is no longer working for us. So, if you could please remove those people from your affiliation list so they are no longer under your medical director's license and we can get them off the company roster. If you would verify your personnel list with affiliation list, that would be very much appreciated. Anybody have anything for me? That's all I got.
Thank you very much.

Will Rosenberg: Thank you, Mr. Barquin. All right, anyone else for SOCALR? Hearing no more, we'll go on to MIEMSS Clinician Services Report, Mr. Edwards. If Mr. Edwards is on, I guess. All right, no, Mr. Edwards.
Anyone else want to speak on behalf of Clinician Services? All right, moving right on down to committee reports.

Clinician Services – Aaron Edwards unavailable. No Report.

Committee Reports

PEMAC Report – Jill Dannenfelser

Jill Dannenfelser: Only thing that's important is that there's new pediatric trauma reference cards that were made. Cindy has them. They're cool and very informative. They're mainly for hospitals. I know Cindy's on that.

Will Rosenberg: Cindy, I'm sure you want to add?

Cyndy Wright Johnson: Jill has highlighted the newest thing. The posters that will come out for trauma and burns are at the printer. I think the printer is running them. Those will be for hospital and for EMS and re-emphasize the new burn assessment. The cards are designed for those with prescriptive scope of practice for in-hospital physicians and APPs. Our real focus there is to help them remember the new pediatric research algorithms to decrease radiation. Happy EMS week to everyone, and I look forward to seeing you sometime over the summer. We are working on that critical patient protocol. Dr. Levy and Dr. Anders are getting together at Hopkins sometime this week or next, and then we'll present it to the pediatric protocol subcommittee of PEMAC, then PEMAC, and then the protocol committee by July, realizing all of this is 2026 protocols. Happy to answer questions.

Will Rosenberg: Doesn't sound like anyone has any questions.

Cyndy Wright Johnson: Sounds good.

SEMSAC Report – Danny Platt unavailable. Mike Moretti advised no report.

MIH Report – Deb Ailiff unavailable. No ProCare members available. No report.

Old Business – Will Rosenberg

Will Rosenberg – Any old business?

Scott Legore: All right, so just to update, the ALS Non-EMS Driver regulation change, it was published on April 18th. Comments closed May 18th, which was earlier this week. Once it's approved by the EMS board, it should become effective three to four weeks after that. I'll let everyone know when the changes go into effect.

Will Rosenberg: Thank you. Scott, any other old business? Moving on to new business. Any new business?

New Business – Will Rosenberg

Will Rosenberg: I do have one thing that I asked Donna to add to the agenda. It could be new or it could be old business. About six months ago, it was dropped in this committee's lap on our thoughts on the EMS Compact. And most people in the committee were ambivalent, I think really because we were unprepared for the question. And most people didn't have feelings one way or the other. I brought it back for revisit. And I've asked Dr. Chizmar to set something up with Dr. Delbridge and the other staff to try to present it back to the EMS Board before we go into legislation. I want the committee to look in to it, review it, and come back. We'll talk about it in two months. I'm not trying to put you on the spot like we did six months ago. But do a little bit of research yourself. The company that I own is impacted as Arkansas, is one of the 26 compact states. For those of you who don't know, obviously Pennsylvania, Delaware, West Virginia, and Virginia are all EMS compact states. And a lot of people said, both from staff and from you in the room, it wouldn't affect us. But, it would. It would allow any clinician from one of those states, if we adopted the EMS compact, to be able to function here immediately. We all know how slow the reciprocity process is, particularly for EMTs. Paramedics that are obviously national registry it's a little bit faster. But for EMTs it's laborious to say the least, and painful. And I think commercial services will be the most positively impacted if we were to get this through the EMS board, which probably would be a rubber stamp from the Legislature. Some of the concerns, the comments you hear from people, is that 911 services don't like it because they'd have to do background checks on their employees. I'm not sure if they're afraid of what they'll find or what have you, that's the really own only negative impetus to it. They obviously fall under the protocols to the service they work for. People will say, well if they come from the State of Pennsylvania, they'll be able to do things that we can't do here. They will have the skill set but if you read the EMS compact legislation very closely, they will not be able to function to that skill level. They will be able to function to the skill level for the service they work for and the protocols that service observes.
Obviously in the State of Maryland we have one protocol set for the entire state. Many other states are service defined or regionally defined. So, my only comment or statement here in the new business is I want people to look at it and I want to talk about it some more at length at the next CASAC meeting. I guess it'll be July. So, we can take a vote on it and see if this committee is in favor of it. From a commercial services perspective, since most of us already do criminal background checks on our employees, there is no cost, only benefit. Again, some of it's going to be an uphill battle from the 911 agencies because they don't want do background checks on our employees and I can't speak to why that is. I know Dr. Chizmar may have had some thoughts, and Scott may have some thoughts, so I let them comment on it briefly.

Scott Legore: I tried to follow up on what was presented before. This came up as a question to MIEMSS in reference to military folks crossing borders. It never went much further than that. It did not get any support at the EMS Board or SEMSAC previously. It will require, if you're moving forward with it, it will require legislative change. It requires what's called the Replica law to be enacted to allow it to happen. So, it would be a process. I know I talked to Christian on a different topic. I think language or legislation must be presented September, October time frame for the January session if you're looking for that.

Will Rosenberg: Sorry, I had to turn my computer back on so we didn't echo here. Dr. Chizmar or any other or anyone else on the phone have any thoughts, comments, questions about it? Lively group or you can't hear us anymore? I'm not sure which.

Cyndy Wright-Johnson: I can hear you.

Will Rosenberg: Okay, that's good. That's at least some validation. At least someone can hear us. All right. Any other new business?

Scott Legore: All right, so I have one, and it's just a FYI for right now. We're not sure where this is going to go. Claire's office issued a cease-and-desist order to a stretcher van service that was operating without a license in Maryland, wasn't even licensed with WMATC. When we issued the cease and desist, this owner came back that the legislation or the regulations were significantly outdated and is pushing for stretcher van legislation. Not sure where it's going to go. It looks like he's not going to back down. So, we've had some internal discussions on our end. Our thoughts are, if he chooses to push this, we would much rather be on the front side of this as opposed to reacting to some legislation that comes from an uneducated legislator. So just throwing it out there, the first question, do we allow little vans in Maryland or not? And then the second question, if you choose to allow them, who regulates them? Are they medical, which would fall under MIEMSS, or are they transportation, which would fall under the Public Service Commission? And then from there, what regulations need to go into place if you were to have litter van services? Again, not sure where this is going to go. However, this owner seems to be pushing forward with it. So, we did throw it out to the EMS board at their meeting last week just to make them aware as well. There seemed to be some interest from the hospital side of things to move a certain subset of patients. Again, not sure where it's going to go. Just throwing it out there so that everybody's aware that this may develop soon.

Will Rosenberg: I would ask the group to speak on your thoughts here, and I think we need to kind of give our opinion to the EMS board, whatever the group's thoughts are. I don't think we want to be silent on this matter either.

Scott Legore: I would encourage you two ways, one, if they should be required or not, and then two, if they are required, again, what the regulations would look like. I have some personal concerns, you know, operating a stretcher van with a single operator. And to me, it's not safe to move somebody on a stretcher with a single person. So, if I was writing the regulation, it would require two people. But again, you guys may have some other things that I wouldn't think of with regards to the business side of things that we may need to include in the regulations. So one, if you think they should be allowed or not, and then two, what the regulations should require equipment-wise, personnel-wise, that kind of thing, if it were to go down that road. Again, I don't know where it's going to go, but we thought from our side of the house we should be on the front side of it as opposed to reacting to something.

Dr. Chizmar: I apologize. I lost my signal there and I know you were calling on me, but I don't want to go out of order.

Will Rosenberg: Let's wrap up the stretcher van conversation. We'll come back to the EMS compact in just a second. From my colleagues on the phone, thoughts on the

stretcher van. If you just want to raise your hand, I'll go right around the room and we'll go from there. All right, Mr. Oliveira.

John Oliveira: No way, bad idea.

Will Rosenberg: Mr. Moretti put a big thumbs down. Mr. Moore.

Jason Moore: Are we talking putting a stretcher inside of a van or is this like the beefier version of a wheelchair?

Will Rosenberg: Well, I can tell you the overall thumbs down are going left and right here. I got Mr. Pixton's. I got Hart to Heart. I got County Medical and I think I missed one as well. I haven't seen a thumbs up come across my screen. Oh, there goes Tyler Stroh, Even the Maryland jockey Club, who I love dearly, is against it. If that doesn't say something, I don't know where we're at. Okay. Can I have a motion to strongly oppose stretcher vans in the state of Maryland? Motion. Second. Claire, I think Claire wanted to say something now that we're in discussion of the motion, let Claire speak.

Claire Peirson: There was a question in the chat box about whether you could get a copy of my letter, and it is public, and I can give it to Scott for those that want it. But the question was, what was the position of our office? And it's a MIEMSS position and a legal position, which is that ambulance transport in Maryland, that an ambulance includes, the definition of ambulance in Maryland law includes stretcher transport. And therefore, stretcher patients have to go by ambulance and cannot go in a stretcher van.
That's sort of the basic position we take in the cease-and-desist letter when we find folks or when MIEMSS finds folks operating an unlicensed stretcher van. I can send the letter which we issue these letters pretty frequently and Scott can send an example or the specific letter to anybody that wants to contact him.

Will Rosenberg: I ask that Donna send it out to the distribution group everybody has a copy of it. Dr. Chizmar, do you want to comment on this before we take the vote?

Dr. Chizmar: No, I guess I would just offer the feedback from Montgomery and Prince George's County and then there's there was feedback from the facility standpoint about availability of BLS ambulances. I think, as it was highlighted, I think it can be a slippery slope between a stretcher van and a BLS transport and so I don't have a strong feeling one way or the other.

Will Rosenberg: Does anyone have Dr. Delbridge's position they want to speak on this?

Scott Legore: I can share a little bit. His concern is that we allow it in two counties and not the other 22. Not that we allow it but WMATC oversees it and it is allowed in Maryland two counties versus the others. That is a little concerning on his end. If this were to make its way to a legislature, he thinks it would have some teeth just because it's already quote unquote allowed in there. But I don't know that he is supportive of the litter concept. We've issued 17 cease and desist orders in the three years to the companies either operating outside the WMATC area or operating within Maryland without a license.

Will Rosenberg: Thank you, Scott. Rob Weiss asked Claire, how does the cease-and-desist order work if you don't currently regulate them anyway?

Claire Pierson: We issue a cease-and-desist order. Thus far it has always brought people to the table. I guess we do have a little bit of follow-up. We don't have a ton of follow-up regulatory authority, but we do have some follow-up regulatory authority in terms of clinicians. We have a lot more authority to get court order against people who are practicing EMS without a certification or license. And so, I suppose if we were really challenged, we could try to tackle it. There are some criminal penalties for operating an ambulance without compliance with the regs and again I don't know that I'd ever find, being candid, I'm not sure that I ever find a state's attorney who would think that this was on the top of their list but we include those penalties in the letter. This has been the first real pushback that we've had. This person said you know understand the laws, you explain it, and I'll certainly comply with it, but I will also seek to change it.

Wil Rosenberg: I think, Claire, isn't it, I don't want to speak for you, but I mean, I think we've, the reason we send the cease and desist is because we say if it's going to, if the vehicle has got a stretcher in it, that outside of Montgomery and Prince George's County, we consider that either an ambulance or something that we, we would regulate and we, because we don't have a regulation, why we send them a cease and desist is that it's sort of getting that wrong. That's the reason why we send that cease and desist though is because in effect outside of Montgomery and Prince George's County it could be construed as an ambulance because we're silent.

Clair Pierson: That's exactly what we say, you're operating an ambulance without a license. And, there's an old, if you guys want Donna to send that too, I don't know how interesting you would find it, but there's a formal opinion of the Maryland Attorney General from 1995 that says exactly this, that says, we determined that a transport of a patient in a stretcher fits the definition of ambulance. The crux of the opinion was whether the WMATC jurisdiction preempted MIEMSS's jurisdiction in those two counties and the attorney general's opinion said yes, it does and that's why this is allowed in Montgomery and Prince George's County. But in making that decision they certainly said that a patient being transported by stretcher fits the definition of ambulance. That's the law in which we rely to say the stretcher vans are operating an ambulance without a license. That's the basis for the cease and desist.

Will Rosenberg: Rob says, thank you. Any other comments or questions? And I have two statements, one question for Claire and one statement. Claire, how come WMATC gets to overrule the legislature on Montgomery and PG? I understand that's the way it is, but it drives me. I don't understand how the Washington Metro Transit Commission overtakes the state of Maryland.

Clair Pierson: It's set up by federal law and federal law overtakes the State of Maryland.

Will Rosenberg: That makes sense. I wasn't aware WMATC was set up under federal premises so, but I guess since it's a District of Columbia that doesn't surprise me. Mike, I would ask you once we take this vote to make sure you get Danny's ear as

he's our SEMSAC representative. I think, unless I'm very surprised, it's going to be a unanimous vote in support of this motion to highly oppose any stretcher vans outside those counties where we have no authority.

Mike Moretti: Yeah, I'll brief him on it.

Will Rosenberg: Thank you. So, we're just going to start with the "No" votes.
Is anyone opposed to the motion as presented? Hearing no objections, we're to go with unanimous consent of the motion. And, I think in case this gets away from us and the EMS board, and our lovely legislature does things that we don't want them to I'm going to go ahead and make a motion that should they usurp our opinion and authority that should they allow it, that it be regulated under MIEMSS. I just need a second. Seconded by Jill and Joe.
Any discussion on that motion? All right. Any objections to the motion? We're going to go ahead and pass that with unanimous consent as well. I'm going to turn it back to Dr. Chizmar and circle back to the EMS Compact now that he's not having technical difficulties.

Dr. Chizmar: I don't want to recap too much, but where we were with the EMS Compact was it was put out to all the various groups for feedback and input.
I don't think I'm mischaracterizing when I say that there was not anybody in support of it. Some of the reasons cited were more trivial than others, and I don't aim to say what think is trivial and what's not, but some cited the, you know, the FBI background check, which I think, you know, in my non-legal opinion, not qualified opinion any more than anybody else on this call, you know, is probably something that most services and employers probably want to do. But it was cited, you know, $18, $20, who's going to absorb it. That, to me, seems like more of a trivial thing, something that could be worked past if it was really all that important. The more important piece was the issue, that many cited, were that they would lack familiarity with the Maryland system.
So, if you imagine, you just pluck somebody out of the West Coast, put them in Maryland, tell them that they've got a permission to practice. The concern is that those people never actually have to become Maryland licensed ever.
It's not like when you move to North Carolina and now you have 60 days to transfer your driver's license and your license plates and whatever. Those people never have to be licensed in Maryland. At least on the 911 side, several of the counties have told me if Maryland ever did this, we just wouldn't affiliate them because they have a degree of discomfort with the person never being licensed in Maryland, not having familiarity with Maryland. We have people who roll from one service to the other with significant clinical concerns that we attempt to stop. Now that bandwidth instead of going county to county goes across the whole country. From the medical directors' opinion, from not me, but the medical directors as an aggregate, there's a lot of concern and then probably more to your point, what are the economic effects of becoming a compact state as you get more and more compact states online? Are you guys likely to see a net influx or a net outflow of EMS clinicians? In other words, could this hurt you economically? That's not my business, but I don't think anybody that I've talked to so far really has the answer to that question. So those were some of the pertinent issues that were brought up. Dr. Delbridge, when I brought the question to him, conveyed to me it was near universal that nobody wanted this thing.
It requires the passage of model legislation as is. He's not wanting to take something

forward or ask Christian Miele, who I think is on the line, to take something forward that has no support from the EMS community.

Will Rosenberg: I think, you know, my humble opinion, just when it was dropped here, I think it had no support because people really didn't understand it. And I think it's more education than anything else now. Again, for the states that it involves, you know, I'm directly involved with, I would tell people it's opened many conditions that otherwise couldn't cross a mythical line in the sand, you know, for example, D.C. to Maryland. I know D.C. is not a compact state currently, but there are certainly, on the shore Delaware, Pennsylvania, and Maryland, for Keystone and Lifestar could open many clinicians that could flow easily back and forth. For those services out in Western Maryland, for County, for Mr. Harsh and his team, and all the people out to the West, it would allow them to have clinicians that lived in one state and could work in another.

Dr. Chizmar: Not to interrupt you, but that did remind me, I left off one point, which was the idea that to some degree, getting a license in Maryland is, I think everybody agreed to this. These aren't my words, but was bringing your national registry, getting a license in Maryland was relatively simple. We brought the regulation forward to remove the fee. I think there was still a fee associated with being commercial versus being public safety or 911. We removed that fee, so there's no fee there. I guess long story short is, if you have your national registry credential and you're in West Virginia, Pennsylvania, etc., in a way, whether it's designed to be or not, it serves almost like a compact, and I think that was why some people also saw less of a need to go down the formal compact road, as opposed to, you know, bring your national registry here, take the protocol orientation, and become licensed, it's definitely not a money grab on our part, we don't make any money per person that we sign up.

Will Rosenberg: Well, as Joe asserted in the chat, and I think I've heard other people assert, and I think I asserted, that is true of a paramedic or anyone who has their national registry card, how that is not true of EMTs. It is a very burdensome, laborious, and excruciatingly slow process. No disrespect to the new director, but it hasn't gotten any better.

Dr. Chizmar: That's very fair. And like I said, it's not one single factor, but those were the things that were pointed out when we had the first round of discussions. So, the group wants to kind of change that perspective and take a second look at it. I think the table is always open, but there were no plans to move forward with it based on the feedback we had in the first round.

Will Rosenberg: Well, there's always a good time for a second round. Any other thoughts or comments on EMS Compact? Like I said, I'm going to have this on next month's agenda. Let people do their own little research, their own digging, their own thoughts, and if the group doesn't support it, so be it.
But I think we were undereducated and underwhelmed the first time, unfortunately. It was kind of dropped in our lap.

Will Rosenberg: Any other new business from the committee?

For the Good of the Committee – Will Rosenberg

Will Rosenberg: Anything for the good of the committee?

Adjournment – Will Rosenberg

Will Rosenberg: I'll take a motion to adjourn or you can just hang up your go-to meeting, whichever you prefer. Have a great day, ladies and gentlemen.
(Everyone virtual disconnected / hung up.)

Attendance:

In Person:	Will Rosenberg, Scott Legore, Marty Johnson, Donna Geisel, Jill Dannenfelser.
Virtual:	Dr. Tim Chizmar, Jim Pixton, Joel Atwell, John Damiani, Bobby Harsh, Jimmy Harsh, Joe Gamatoria, Jason Moore, John Olivera, Mike Moretti, Tyler Stroh, Lara Snyder, Rob Weiss, Jeff Kreimer, Claire Pierson, Scott Barquin, Todd Abramovitz, Stephanie Ermatinger, Christian Miele, Cyndy Wright-Johnson, and Justin Kinsey.
Callers:	Scott Legore – Due to Internet connection issues.