CASAC Meeting
Minutes – January 21st, 2026

Meeting called to order by Chairman Rosenberg

Approval of minutes – the minutes from the November meeting were sent out by SOCALR.
Are there any additions or corrections to the minutes? None
Motion was approved and seconded.
No objections to the motion – minutes approved.

State Medical Director's Report – Dr. Chizmar

Dr. Chizmar reported that the protocols for 2026 are actively being worked on. There are no new medications and no new devices that the PRC are looking at for the 2026 year. There are a couple of protocols that are going to use meds that we already have, but in different ways, such as Labetalol for some cases of hypertension. In addition, a little bit more Midazolam for seizures and Ketamine for seizures as well. There are no new proposed devices or new meds included in those changes. This should be a good thing from an operational perspective.

In Dr. Delbridge's absence, Dr. Chizmar mentioned two legislative bills that MIEMSS is following. One is the AED bill, which is pretty straight forward and just clarifies and cleans up the existing AED legislation. For instance, the AED law right now speaks to there being regional quality committees and so forth, which have not existed in over 15 years. Nothing controversial about the AED bill, just cleaning it up and really should be no impact. There's a Senate Bill 159, which may impact jurisdictional programs a little more than commercial services. Senate Bill 159 was proposed by a delegate, a senator from Prince George's County, that would require the executive director to develop a mandatory equipment list and would also require some jurisdictional reporting on quality measures on a quarterly basis. Dr. Chizmar did not see any specific reference to commercial services. Commercial services already have a mandatory inspection process, so Dr. Chizmar does not see how this bill would change anything for commercial services. He wanted to mention it as a matter of general interest in case that bill takes a turn or evolves. It hasn't had a hearing yet. He thinks the hearing is to be in February. Sometimes bills come in looking like they're going to be one thing, and they end up becoming something altogether different. People might decide they want to weave commercial services into that bill in some way, shape, or form. Mentioning it to you so you are aware of this bill.

Looking forward, Wednesday, April 8th, will be our 31st Annual Medical Director Symposium. We'll be hosting at Howard County again from roughly 8 am until 2 pm. He is currently working on forming the agenda. I would like to open up the opportunity to all of you if you have speakers from your services or speakers that you know of or

topics that you are interested in hearing about. He is open to any suggestions. Let Scott or Dr. Chizmar know if you know of a speaker or have a topic of particular interest. Currently we have a variety of speakers, both medical and operational. However, we don't have a full agenda so we are certainly happy to hear if you have any suggestions.

Dr. Chizmar advised his last pieces of information he has to share are administrative. His assistant, Stephanie, has departed from MIEMSS. Dr. Chizmar mentioned a lot of people reached out to him directly. You don't need to send any emails to Stephanie's email address as they bounce back to him. The other piece of information is that Meg Stein, our protocol administrator, is going to be back as of today working on the protocols. Plus, we are delighted to announce that we have Brian Ashby joining the Protocol Review Committee at the March meeting. That will be the second Wednesday in March, which will be March 11th. Brian Ashby is a paramedic with AAA. And then we will be reaching out to John Hopkins Lifeline. We are going to ask if their submission would be willing to be the alternate on that committee as the Commercial ALS representative for the PRC. Congrats to both of them and thank you for submitting their names.

Scott Legore asked Dr. Chizmar if he would like to talk briefly about the Diltiazem shortage. Dr. Chizmar mentioned that we did put out a memo since CASAC's last meeting regarding the Diltiazem shortage. The storage is on the lyophilized powder form of diltiazem. It comes from a manufacturer's decision just to not make it. My understanding is there's still maybe one manufacturer that makes lyophilized diltiazem, but it's very small in number. So, we put, as an alternative out there, metoprolol. I'm hearing now that there are some manufacturer shortages of metoprolol vials as well. But it tends to be a little bit more widely available than lyophilized diltiazem, which is not being made at all. The memo, as well as the emergency protocol, are listed on the MIEMSS website under protocols. The only thing we ask is that you notify Scott Legore and copy me if you intend to switch over to that. And I think, Scott, you plan to handle that as a waiver like you do with all the commercial services. As another option, instead of switching to Metoprolol, they still make Diltiazem in vial form. The only challenge is you have to either refrigerate it of if you keep it out of refrigeration for more than 30 days you have to toss it. Probably the fourth line option down would be to use Verapamil. It was my intent to pull Verapamil out altogether because it causes a lot of hypotension. That was my intent until this morning when I found out there were issues with Metoprolol. Anybody have questions on that, on Metoprolol, Verapamil, Diltiazem, or any of the shortage issues? Also, does anybody have any other pressing shortages that you've just become aware of that we may need to think about alternatives for? No one spoke up about issues and/or shortages.

SOCALR Report

SOCALR 2025 Activities – Scott Legore

Scott opened up a power point presentation to show SOCALR's 2025 activities.
There are 31 BLS services in the state, 20 of them are ALS as well, 13 are SCT, 7 NEO, and 7 are Air.
There are a total of 486 ground units: 305 are BLS & 181 are ALS.

17 more units than last year.
We have 28 licensed AIR units.
For response stats, there were 278,293 commercial service transports.
82% were BLS transports, 13% ALS transports, and 5% SCT transports.
SOCALR's activities included:
78 renewal inspections, a total of 457 units.
51 inspections for new units or transfer licenses for another 82 units.
15 SCT inspections, 7 NEO inspections, and 11 Base inspections.
SOCALR did 2 new service inspections, 4 upgrade inspections, 4 site visits, 7 investigations, and 2 non-compliance meetings.
As for Random inspections, we did a total of 72 random inspections.
We went out 76 days, visited 494 sites, observed 293 units, inspected 72 of them.
22 of the 72 random inspections had deficiencies, so about 30%.
The deficiencies included 6 with unsecured equipment, 7 with missing equipment, 8 with expired medications or equipment, and one had an unaffiliated person onboard.
Scott asked if anyone had questions. No one spoke up.

Inspection/License Update – Scott Legore

SOCALR is getting ready to start the 2026 renewal process. Just an update, we've been able to move the entire process online to Smartsheet, so we will be rolling that out. With the March renewals, which will go out February 1st, you will be able to submit all of your information through Smartsheet. As your service comes up for renewal more information will be sent out to you. It has its own dashboard that allows your service to move through the process and submit documents directly to us through the renewal dashboard. As part of the renewal process for 2026 we are going to be asking for the services to submit updated OSP training materials. If you have had an OSP that's been approved longer than 5 years we're going to ask you to submit your updated training material for that OSP. Some of the OSPs have been out there for 20 plus years and we have not collected any updated training material so we are going to go through this process. We won't hold up your renewal but we are going to ask for it as part of the license renewal process so that way we can spread the review throughout the year so we are not bombarded with 31 services submitting their training material all at one time.
Will Rosenberg asked if there's something relatively recent, you're not going to ask them to redo everything, right?
Scott Legore went on to say in some cases there might be information that is still relevant, but anything more than five years old we need to look at this to see if they are using outdated protocols in their training materials and items similar to this. We discovered this issue by accident, but once we discover a problem, we want to fix it. So, we are going to ask everybody to make sure that they already have it updated. It's just submitting the right stuff. But, if you haven't updated your training materials for a couple of years, make sure you dust them off and you are properly reflecting the current protocols and whatever devices you are using.
We found in some cases, on the commercial side and jurisdictional side, that some people are not even sure which OSPs they actually have. They apply for an OSP

that they have, but haven't used in years. Your OSPs are shown on your dashboard and we send that information out yearly with your renewal information to be reviewed.

QA Review/Data Import – Scott Legore

Scott Barquin has been sending out monthly updates for anybody that has unidentified clinicians on their reports. He has also been working with any service that has been having data import issues. Reach out to him if you need assistance.

Equipment Update – Scott Legore

Prior to the meeting I sent our updated BLS and ALS equipment checklists. There're actually no changes to the checklist. It's just cleaning up the language on the checklist. We had one that was a service request, one was identified during an inspection, and then one was a discrepancy with the way the medications were carried. So, on the BLS list, the changes to the list are just the order of the medications on the list. We moved activated charcoal and naloxone down on the list and put it underneath a block that says that the below medications are not required for interfacility transports. However, they are required for 911 contracts, event standbys, and mass casualty deployments. Then under the Rescue Vac, the handheld suction device, it used to say optional for BLS units in place of battery powered suction. A service took that as believing that was an option for the unit where you need to have battery power or a rescue vac for BLS units. So, we changed the language to say substitute for. You either need a battery powered unit or a rescue vac or an approved alternative with us. That was the changes to the BLS list. The ALS list had changes regarding naloxone. We added a line below naloxone that it must be carried in a formulation that can be administered IV, IM, IN, and IO. You must be able to carry it in some type of syringe-type format so that you can administer it the ways the protocols require. We had some services carrying just IN naloxone on their ALS units and that doesn't work with our protocols. In making these changes, Dr. Chizmar and I identified several other items that we believe need to be carried on units that are doing 911 contracts. We are going to put together a separate checklist for the 911 contract units and will keep it different from the commercial units because it will only apply to a few services. Currently on the BLS checklist there are no tourniquets, splinting materials, and stuff like that, which you probably need to have on a BLS unit if you are doing 911 or event standbys. You are going to see a separate checklist for the units that are doing 911 contract work and stuff that is commercial, so you properly cover the protocols. That will be coming out within the next month or two. Any questions on the equipment checklist? No questions.

Will Rosenberg questioned if Scott Legore could disseminate the PowerPoint he showed. Scott advised he would get that out to everyone by email.

Clinician Services – Aaron Edwards

Aaron Edwards advised Clinician Services are in the middle, or getting near the end, of the recertification cycle for the January 31st expiration date. We are down to about just over 700 people. Out of those 700, 300 of them are not affiliated. I think there's probably about 30 that are working in commercial ambulance services. We will be reaching out to each of those companies to let them know that their clinician is getting ready to expire. Other than that, the reciprocity is still going pretty well. It's around 10 days with around 10 days of waiting for the protocol orientation. We have made it fully automated so we don't do anything anymore. You don't have to wait on that. It's all going to be based on the clinician and the service. We do recognize that there's an issue with inactive people. People are getting their reciprocity, putting in an affiliation request, and getting their affiliation, but not asking to become active. We are working with ImageTrend to try and fix this situation so we don't have it occurring. We hope to have that done by the end of the month. Any questions? No questions asked.

Committee Reports

PEMAC Report – Jill Dannenfelser

Jill Dannenfelser advised she did not have a report unless Scott Legore would like to give an update on the new Neonatal classes that he brought up at PEMAC. Scott advised he was going to bring it up during new business but he could bring it up now. Scott advised there was requests from two services to recognize some alternative classes to NRP and STABLE. SOCALR ran this through a variety of committees internally and also had a virtual call with all of the neonatal services. There were 6 or 7 neonatal services and 4 or 5 commercial services on the call. The request is to recognize the American Red Cross neonatal advanced life support class as an alternative to the NRP that's required within the regulation. Based on our research, they are pretty much equivalent. We will recognize that class. Because of the way the regulations are written, if your service wants to do that class it will require a waiver. I issued 2 waivers already to the services that requested that class. However, if there's other services that are looking to do that, feel free to contact me. The other request was to recognize the NAEMT EPC course as an alternative to STABLE. Our view is that they are not equivalent. We're still looking for some additional information if the services want to provide it, but at this time we are not going to recognize that one as equivalent. So, currently if you would like to use the American Red Cross Neonatal Advanced Life Support class, we need to do this through a waiver. Reach out to us if you are interested. Based on the discussions with the neonatal services, none of the hospitals are looking to change NRP and STABLE for their personnel. This would probably just be for the EMS clinicians as an alternative as it's a little bit easier to obtain and the course is geared more towards EMS clinicians and hospital personnel. Any questions about that?

SEMSAC Report – Danny Platt

Danny Platt advised that SEMSAC did have a joint meeting with the EMS Board last week. Dr. Delbridge presented a very good MIEMSS annual report. The report had a lot of good information in it. Everything else discussed during the meeting was covered through Dr. Chizmar's report. Danny recommended that we send out the MIEMSS annual report and Scott Legore advised he would get it sent out in the next couple of hours after this meeting. Will Rosenberg pointed out that one of the most important things to note in the report is that out of about 900,000 patients transported in Maryland, 600,000 by EMS, and almost 300,000 by commercial services. This means we account for just over a third of all patients transported in the State of Maryland. Keep that in mind. Danny advised that Dr. Delbridge did bring up the importance of commercial services. Any questions? No questions.

MIH Report – Deb Ailiff (Not available) - No report.

Old Business – Will Rosenberg

Any old business? No old business to discuss.

New Business – Scott Legore

Elopement – SOCALR has implemented an elopement tracking form. We are trying to get a handle on the elopements that occur during interfacility transports. We recognize it's a problem and we are trying to get a handle on the scope of the problem. We are not looking to make any immediate changes. Right now, it's just to better understand the problem. From there we will have some internal discussion and probably reach out to commercial services for some thoughts on ways that we can improve and make it safer for the patient, the EMS clinician, and try to minimize the number of elopements that occur. It's a Smartsheet form, pretty easy, and will probably take you less than a minute to fill out. We just ask that anytime your service has an elopement, you fill out the form and get it submitted to us as soon as possible. We recognize it may not be immediate. That way we can track them. Scott asked if Dr. Chizmar would like to add to this information. Dr. Chizmar wanted to share that in conjunction with reporting it to us, report it with company policy as well. We don't want to take the place of anybody's company policy. And certainly, if this is an involuntary transfer, it's very reasonable to notify law enforcement that the person has eloped so that they can decide whether they're going to initiate the process all over again. Just to elaborate a little bit, we've not had a great deal of information for what the numbers are. I think that the initial survey that Scott did was surprising to some and not surprising to others. Different states handle, particularly involuntary psychiatric transfer, differently through different modalities, some with more of a law enforcement presence and some like we do. I think that this data could be helpful in shaping policy. Clearly if there are a lot of elements, that's not in the pateint's, or anybody's, best interest. I guess my personal opinion, it doesn't sit well with me where we are with regard to elopements right now, and I don't think we've necessarily set out people up for success. Thank you for contributing the data. Hopefully we can drive policy with it moving forward. Any questions on elopement tracking?

SCT Short Form – Scott Legore said he wanted to keep everyone in the loop. We haven't made any action on this yet, but we had a request from one service to look at revising the SCT Short Form for the SCT services. Based on our research that last one was put out in early 2019. So, it hasn't been revised in almost seven years. We may get together a group just to look at that or we may be able to just do it through email and see if the form that they submitted is what everyone wants to go through or if there's other changes that we want to have as a standard form for SCT services. I would hope everyone is using it if they are not submitting reports at the hospital. Anyway, that request has come in and there's also a request from a neonatal service to make some changes to the equipment list reducing some of the medications and some of the equipment requirements. We'll probably do like we did for the classes and get the neonatal group together and look to see if there's changes to be made. Leigha McGuin raised her hand. Leigha said she was hoping to piggyback on the short form. Maybe we could talk offline about resurrecting the SCT committee and she would be in favor of volunteering to contribute to that. Will Rosenberg said yes, I don't see any objection from anyone else in the group. It seems there's a second from Zack over at pulse. The reason it kind of died was there was no topics to discuss. Typically, it was held at noon proceeding this committee. Unless Scott has an objection, I don't see any reason if couldn't be resurrected as long as there's people that want to participate. It got to the point where it was only a handful, like 2 or 3 services showing up. I am curious. I see Pulse is interested and obviously Maryland ExpressCare is interested. Thoughts from other SCT services in the group? Messages popped up in chat. Jonathan Siegel from MedStar said he would be supportive, just wondering what there is to discuss. Derek June, from Christiana Care SCT, would be interested. Owen Siford, from Vesper, is interested. Joe Haney, Hart to Heart, said Hart to Heart would join. Jim Pixton said "same here". Zach Risoldi, Pulse, said that Pulse is interested in revisiting the staffing requirements and scopes. He feels these may bleed into the protocol review committee, but we need to start somewhere. Mike Moretti, Keystone, replied "I am in." Matthew Kravetsky advised STAT MedEvac would participate. Lara Snyder advised PHI will join. Danny Platt said Lifestar will get in. Scott Legore said so the key, so we don't waste anybody's time, is that if you have items to discuss shoot them to him ahead of time so we can get them out to the group. We can have an agenda and have a productive meeting. So, if you're interested and you have topics, we will meet. Will Rosenberg ask Is noon still an open time? I think the March meeting is altered due to a conference. It's not our typical meeting, but we can tentatively plan for the SCT committee meeting to start at noon. Please send your topics in to Scott, Will, and you can copy Leigha, if you wish, or the entire group. That way we make sure we come with some content and purpose. Leigha thanked the group.

Dr. Chizmar spoke up to add a very brief announcement. Several of you have nurses that are not necessarily base station trained through their hospital. The base station training basically provides them with an online primer, it's how to do that. It was in person before. The entire base station class has been migrated online. It's available through the online training center as well. Dr. Chizmar will share that with Scott so we can get that information distributed out. That's really probably only relevant for the SCT and NEO services. Hopefully that helps everybody get that done a little bit faster.

Will Rosenberg asked if there was any other new business. He mentioned that we would hold an SCT committee meeting one hour before our next CASAC meeting, so the SCT committee meeting would be on March 19th at noon.

For the Good of the Committee - None

Adjournment

Meeting adjourned

Attendance:

In Person: Dr. Tim Chizmar, Scott Legore, Will Rosenberg, Claire Pierson, Abby Butler, Jason Cantera, Todd Abramovitz, & Aaron Edwards.

Virtual: Donna Geisel, Lara Snyder, Jill Dannenfelser, Zachary Risoldi, Kate Passow, Jonathan Siegel, Danny Platt, Derek June, Steve Rawheiser, Jim Pixton, Mike Moretti, Will Stinson, Wendi Colliflower, Cynthia Wright Johnson, Teddy Baldwin, Owen Siford, Lando Orsino, Matthew Kravetsky, Danielle Telesford, Aaron White, Hali Crist, Justin Kram, Jeff Kreimer, Leigha McGuin, Joe Haney, Tyler Stroh, Heidi Hubble, Rob Weiss, Marty Johnson, Felicia DiFonza, John Pierce, and Mark Nellis.

State Office of Commercial Ambulance Licensing and Regulations

2025 – End of Year Report

Maryland licensed services:

BLS	31
ALS	20
SCT	13
NEO	7
AIR	7

Maryland licensed units:

486 Ground units

BLS	305
ALS	181

+17 from last year

AIR	28

State Office of Commercial Ambulance Licensing and Regulations

2025 Response Stats

2025 Commercial Ambulance Service Transports

BLS	228,068	81.9 %
ALS	36,088	13.0 %
SCT (Nurse)	11,488	4.1 %
SCT (Paramedic)	2,649	1.0 %

Total Transports 278,293

State Office of Commercial Ambulance Licensing and Regulations

2025 Inspection Activities

Renewal Inspections	78 Inspections	457 Units
New Unit/Transfer Inspections	51 Inspections	82 Units
SCT Inspections	15 Inspections	
NEO Inspections	7 Inspections	
Base Inspections	11 Inspections	
New Service Inspections	2 Inspections	2 New Services
Upgrade/Downgrade Inspections	4 Inspections	4 units

Site Visits	4 visits
Investigations – On Site	7 visits
Non-Compliance Meetings	2 meetings

State Office of Commercial
Ambulance Licensing and Regulations
2025 Inspection Activities

Random Inspections

Days: 76
Sites: 494
Observed: 293
Inspected: 72

22 w/deficiencies (30.5%)

Unsecured Equipment – 6
Missing Equipment – 7
Expired Medications/Equipment – 8
Affiliation - 1