CASAC Meeting
Minutes – May 20th, 2026

Meeting called to order by Chairman Rosenberg

Approval of minutes – the minutes from the January meeting were sent out by SOCALR.
Are there any additions or corrections to the minutes? None
Motion to approve by Jill Dannenfelser and seconded by Matt Larrabee.
No objections to the motion – minutes approved.

State Medical Director's Report – Dr. Chizmar

Dr. Chizmar wished Chairman Rosenberg and everyone in the room and online "Happy EMS Week".

Dr. Chizmar announced that his office has identified a candidate to be their administrative assistant and they will hopefully be onboarding that person by the end of the month.

The protocol updates for July 1st, 2026 have been released for a couple of weeks now. ALS and BLS updates are both online and available. He has been working with Media Services set up an app so that people will be able to complete the updates on their mobile devices. You can use the Moodle app, and there is a three-step set of instructions on how to utilize the Moodle app. Maybe Aaron Edwards can cover it in more detail than Dr. Chizmar can. The spiral protocols are available here, same as they have always been. They cost $10 per book and it is under what it cost us to print them. Last year we printed around 150 to 200 full size protocol books. This year we are going to print those "on demand". Usually those are students who want them. The full size, 8x11 size, will cost $25. If you take it to be printed elsewhere it will run around $75. So, if you do have people that want a full-size protocol book, we will still do those "on demand".

The only other update that Dr. Chizmar had was regarding the SCT subcommittee meeting that met just before the CASAC meeting. He came into the meeting at the tail end of it and was brought up to speed. Scott Legore actually has some slides under his report that he will share so that everybody has that for their awareness.

Will Rosenberg asked if anyone had questions for Dr. Chizmar. No response.

SOCALR Report – Scott Legore

Inspection/License/Renewal Update – Marty Johnson
Marty indicated that as far as the renewals for this year, there have been only a couple of issues. We had some invoices go out with the old pricing somehow. He

is not sure how that happened because once the prices are updated, they are saved and locked. But, still a couple of invoices got out that were incorrect and had to be corrected. Smartsheet is running perfectly well with no issues. We do have some issues with the payments of invoices, but everyone seems to be using the document portal for their renewal paperwork. It's going well.

QA Review/Data Import – Scott Legore

We don't have anything on the data imports.
If you have any issues with either unaffiliated or unidentified clinicians, Scott Barquin will be reaching out to you. I think he sends those updates out on a monthly basis.

Equipment Update – Scott Legore

We sent out the new equipment checklists yesterday. No new equipment on the checklists. There were some wording changes that just was to clarify some things.

The big change on the ALS trucks, the video laryngoscope is now required. If was added last year and everyone had a one-year grace period to obtain that equipment. Now it will be a requirement as of July 1st, 2026.

Smartsheet – Scott Legore

Marty mentioned that everything is going good in Smartsheet. However, we had some issues over the weekend. We received some spam entries through our Smartsheet forms. So, no service is doing anything wrong, but the spammers are now attacking Smartsheet. So, step one of our processes to try to reduce this problem is to remove the links from the MIEMSS website where the public can see it and try to use it. The forms will still be on the Commercial Services Dashboard and on your individual service's dashboard. We are not changing the forms or changing the links. We are just removing the links from the MIEMSS website. So, if that is where you normally go to use the forms, they will probably not be there. We can send you the links if you want them in an email. Due to the spam, we may also be reaching out to the services just to verify information. Today we had an entry that came through the Monthly Data Report form. It came from an unknown sender and it had data that was clearly wrong. We did reach out to that service to verify the information. It was spam.

New Service – Scott Legore

Director Legore announced that we have a new service that is probably going to be licensed next week as soon as we go out and finish up their vehicle inspection. They are Golden Days Transportation. They are going to have one BLS unit to start.

Extraordinary Care – Scott Legore

We had a question come through Dr. Chizmar's office regarding the extraordinary care protocol. The question was "Can the extraordinary care provision of the protocols be instituted due to short staffing?" And the short answer is no. If you

service does not have a nurse, you can't say "Hey, we're going to institute the extraordinary car provision because we don't have a nurse to take the patients." Just throwing this information out there since the question came in.

Elopement – Dr. Chizmar

Dr. Chizmar had a question about the elopements since we recently started using Smartsheet to track elopements. There have been a handful of elopements reports since we started tracking them on Smartsheet. He vaguely recalls that one service was looking into a new design of a vehicle. He thought it might have been Keystone, but he was unsure. Dr. Chizmar's question, "Did that new vehicle or way of doing things come to fruition at all?" Mike Moretti, from Keystone, advised they did start using a transport, a van with a power transit with some training and stuff, but he was not exactly sure of the actual configuration of that unit. It has been fairly successful so far. Dr. Chizmar questioned if it is locked, as far as the occupants go in the back of the van? Mike thought it was locked. He said the drivers also receive extra training for de-escalation and so forth. Mike said he would work on getting more information on it. Dr. Chizmar said that he is thinking out loud, but if there is something working or something we can do to reduce the number of elopements, then we need to work on some sort of new way of doing things to minimize the elopements. He just wants to keep that out there on our radar. Mike pointed out that they, Keystone & Lifestar, still have their behavior health policy in place that Dr. Chizmar reviewed. Dr. Chizmar questioned if that is with the seatbelt device. Mike advised "correct". Dr. Chizmar recognized that Keystone's experience in PA has been better than it has been here in MD in terms of elopements. Mike advised they had four elopements up PA in the 10,000 transports that they have completed. The elopements were mostly because they didn't apply the straps appropriately. Dr. Chizmar questioned if they were using the straps down here in MD. Mike advised "correct". Dr. Chizmar suggested to Scott Legore that we talk about this with Claire Pierson or about this with the group in reference to what are other approaches we can do to make the six to eight elopements get down to zero if we can. We put that Smartsheet elopement tracker in place to track it, but as some point, we may want to take some action to make things better. Teddy Baldwin, Lifestar, mentioned that they started that type of vehicle on the Eastern shore. It is essentially a paratransit van. We put a cage in-between the driver and the passenger, and it is like child safety locks, so they can't get out. He also mentioned that they do it for voluntary only. Dr. Chizmar asked for clarification about the cage. Teddy advised it's between the driver and the rear compartment, not between the two front seats. Jimmy Pixton mentioned that they did the same thing, The problem was that hospitals were very uncomfortable with it because there were some issues with it. We used to have a "psych van" and it worked well. It cut down on costs, but the legal people didn't like it and put a stop to it. Jimmy said that it had to do with the physicians. He said the physicians didn't want to get into restraining the patients and they didn't want to order sedation if they didn't need to. Dr. Chizmar said that a lot of it does fall on the physicians. It's been made difficult for them. There are CMS guidelines about restraint. For

example, if Dr. Chizmar ask the security crew to hold somebody down, he has to go to the computer and put in an order to "hold them". Then he would have to put in another order to give the patient medications. If he put them in restraints, it's got to be a time thing. And you have differences based on different age groups. It's basically processes that make it difficult to do it, so it makes you not want to do it. We don't want to restrain people who don't need to be restrained. But one could argue that involuntarily patients that tend to elope between hospitals are not a risk-free thing for anybody, the patient included. Dr. Chizmar asked if the Smartsheet form deciphers between voluntary and involuntary? He was told there is a question on that. Dr. Chizmar questioned if all of them been involuntary. Scott advised yes, because usually you don't see it typically with voluntary patients. Some issues occur when there is an adolescent where the parents are signing the voluntary and the kid really doesn't want to go. Kids typically don't get a vote. Also, it's also the adults who know the system. Dr. Chizmar said this information is good to hear from the services who have this experience. He mentioned to Scott that maybe we need to work on this problem and see if there are different ways or better ways to handle these transports.

Will asked if anyone had additional questions for SOCALR. No questions.

Clinician Services – Aaron Edwards

Certification Renewals – Aaron Edward

The Office of Clinician Services is in the middle of the throes of recertification again for EMTs. We have about 800 of them that have already been recertified and relicensed. It's just over 2,000 EMTs that have not.

ImageTrend – Aaron Edwards

ImageTrend is having some issues again and it's having issues with our online training center. They are not communicating well. He has a meeting at 8:00 to discuss many of the issues with Image Trend. It has been going in and out. The public portal has been down over the last week and half on occasion. Bear with us as we work through those issues. So, it's a communication issue and we have found a work around for that. We have been bringing it over every day or every other day. We think we have got that portion addressed, or at least we can fix it.

Moodle App – Aaron Edward

We have the Moodle app. It's an app on the app store. It's on the same platform as the online training center is on. Once you download it, you will go to the same web address on the app and the same online training center. You will enter the same information, your username and password, and you will come up to your dashboard. You will be able to download the entire protocol update or any of the others on there. It will upload to your system there and then within 48 hours it will be back to MIEMSS on ImageTrend. So, if anybody has any questions, we are going to put out a few more specifics on social media and we will probably try to get something on the website as well. You will be able to click on it. There is a

little note that say use Google app if you are using an iPhone. The Apple products aren't working well with the online training center. Any questions?

Will Rosenberg asked if anyone had questions for Aaron Edwards. No response.

Committee Reports

PEMAC Report – Jill Dannenfelser – No report.

SEMSAC Report – Danny Platt - Not available – Scott Legore advised there was no meeting. No report.

MIH Report – Deb Ailiff – Not available. Justin Kram advised No Report.

SCT Committee Report – Scott Legore

The SCT Committee reviewed some changes that came out in the 2026 protocol changes.

Dopamine was clarified as an ALS medication.

Dobutamine got moved into its own category, Inotropes, with the new 2026 protocols.

Vasopressin was moved from RN to SP level within the new 2026 protocols.

Sodium Bicarb now has a footnote that it is ALS up to 150 mEq in 2026 MMP.

Potassium now reads "potassium-containing solutions, with K+ of 20 mEq/L or less" in the 2026 MMP.

The IV Pump OSP now reads "For jurisdictional and commercial services", and the IV Pump was removed from the SCT table in 15.35 2026 MMP.

The Ventricular Assist Devices now reads "if being transported for outpatient appointment, or if being discharged to home or rehab, may go ALS" in the 2026 MMP protocols.

Transport Isolette, they changed the verbiage and updated it in the 2026 MMP. It's like electronically powered for temperature stability.

With the pelvic binder, there was no action required. It was confirmed that it's a BLS OSP.

There was one that still needed some action, and that was Precedex. The request was to add it to the SCT medications. Currently, it would be required to have a nurse because it is not mentioned. Dr. Chizmar added, this one needs to go to the protocol review

committee. So, if one of the commercial reps would like to sponsor it, that would be ideal so that it can be brought to the protocol review committee with new gravity. Brian Ashby mentioned that he will be sponsoring that at the next PRC.

Brian indicated he had another question and it was in regards to the Isolette. He needed Scott to repeat the information regarding the isolette and it being electrically powered. Scott advised that at the last SCT meeting it was asking to be defined as to what is an isolate because some people believe a car bed would be an isolette and other things. So, it was just defined that an isolette is electrically powered, and it's a securement device. It's the fact that it was actually powered and being used for temperature stability. Brian advised that he gets the difference between a car bed and an isolette, but where does the BabyPod and BabyPod 2 fit into that? Cyndy Wright Johnson advised that the BabyPod and BabyPod 2 are also considered by NHTSA and NIOSH to be pediatric restraint devices. They don't meet the criteria as defined by those two national organizations for isolettes. It typically is used for larger children that are going between two locations that don't fit the restraint devices and are not the correct size for an isolette, and honestly don't need all of the advanced components of the isolette. Brian advised that is his question… In his eyes, they don't compare to an isolette at all, except they do fit the need for baseline temperature control. There is a warming pad in it. And, it covers the difference between the PediMate, the NEO pediMate, and those weird child sizes that the BabyPod actually covers the weight. Correct? In terms of securing, we would not sue it as an isolette because there's other reasons you would need an isolette. I just wanted to make sure we are not outlawing them before I order parts to repair the ones we have. Cyndy replied that from everything she has heard at the national level and the discussions we have had a PEMAC, there's no reason not to use a BabyPod. Those standards are being tested by NHTSA this summer. I do not think we will have international SEA standards on how to secure a child to a stretcher until at least late 2027, which has been a 20-year process. She knows many of us are raising our eyebrows or just sighing. But no, the BabyPod is listed as a form of pediatric transport.

Dr. Chizmar summarized that they did 95% of what was asked for at the March SCT Committee meeting and we have a little bit more work left to do for this year. Will Rosenberg added that the only two remaining SCT agenda items that are left to do is the updated SCT short form, which hopefully some people are getting back to Scott Legore so he can continue to get this in front of Dr. Chizmar and modify, and the pregnant obstetrical patients which is going to require some further conversation. That will target a July 2027 change. Dr. Chizmar added that we will need the maternal and neonatal people at the table to look at this again. It's been four or five years since we last discussed this and it's time to talk about it again. There's no mystery to everybody that there are a diminishing number of hospitals that have OB capability or have labor and delivery. Problems are going to keep surfacing and we need to try to prioritize the resources for the calls that actually need a nurse versus the calls that don't. Will added that the current perinatal medical director was very open to conversation as opposed to the previous perinatal medical director, so he feels we may have some traction for further conversation.

Jimmy Pixton questioned if a patient has an LVAD transport that is completely unrelated to the LVAD, it has to go ALS? Dr. Chizmar, Jimmy Pixton, and Will Rosenberg discussed the LVAD patients and transports to clarify that previously those transports went SCT but now we are carving out the population of patients going to doctor appointments, discharges, long-term rehabs, or not going to an actual hospital can go ALS. There was much discussion about these patients calling a CAB, vs going by wheelchair service, or in an ambulance going with ALS clinicians. Brian Ashby joined in the conversation reference patients calling for a sedan or wheelchair service with an LVAD. Jonathan Siegel questioned "If their alarms start going off an their LVAD at home and they call 911 and they're in a jurisdiction that has limited or no ALS, they are going to go to the ER with a BLS ambulance with a single EMT in the back who may or may not know how to manage that LVAD." Dr. Chizmar pointed out that MIEMSS cannot control what is going by the wheelchair services, but if the patient is going with a clinician, we have protocols that addressed those situations. He went on to say that the BLS clinicians are only handling the first couple of lines of that protocol. EMTs across the board are not trained in the care of LVAD patients. There is a limited amount of time to actually provide them with the curriculum and training. He is not distinguishing between the 911 EMTs and the IFT EMTs. He is saying that if somebody called 911, the expectation is that the person with an issue that is related to their LVAD is that they are transported by ALS. The discussion continued regarding LVAD patients being transported for various reasons, ALS or BLS. It was agreed that not all LVAD patients need to be transported ALS, but every situation cannot be written into the protocols. Currently the LVAD patients need to be transported by ALS. We are going to have a similar discussion with the OB people on what a non -pregnancy transport is, or a non-pregnancy related transport is. There is still more work to do. Dr. Chizmar advised he did the work that he could do, knowing that the protocol books would be going out within a week or two of our conversation. He tried to get as much accomplished and to the EMS Board and SEMSAC and so forth so the changes could get into the protocol books. What we want to do, what we should want to do in general, just zooming out from the LVADs, is have the appropriate equipment on the ambulance for the personnel that are one the ambulance to take care of the patient and try not to intentionally put clinicians who don't have the training in the position where they have to take care of somebody that they are not trained to take care of. He was trying to get some things accomplished quickly with the first round of changes and there's more to get accomplished.

Scott Legore advised the arterial line was discussed today. Will Rosenberg advised the conversation at the SCT committee was that we have expanded the scope to an SCT paramedic to do drugs such as vasopressin or other pressers, and we are withholding their ability to then monitor the arterial line. Dr Chizmar to Brian Ashby, so the challenge for you is being able to represent this committee and also be a bi-directional flow of information because you have the patient's best interest in mind. But you also have the committee's interest and you are representing both yourself, ALS clinicians, and the committee's interest. So, when you bring these proposals forward, what we need to know is what is the rationale. Obviously, the ask if clear, but what is the rationale? Why does the committee believe that we should do X instead of Y or B instead of C? So, that's the role that you volunteered for. Brian Ashby replied that he completely agreed with that

and he can sponsor the Precedex and bring that to the table. He didn't bring up the arterial line issue. That was brought up by somebody else. And though he can agree with them, if you are going to give us access to pressors, we need something more accurate than a non-invasive blood pressure. However, he also can see all of the risk of, is one person in the back of the truck going to be able to do all of those items? And what's the outcome if something goes south. Making sure that we all have the capabilities of stopping an issue with an arterial line. Zach Risoldi questioned What about having a nurse onboard makes you more capable of handling that problem? Will Rosenberg indicated that he agreed with Brian. The piece that may be Brian's stop gap to present to the PRC is that the protocols themselves are limited to two or more. So, a single SCT provider is limited to like two interventions in totality, right? Scott Legore answered that they are limited to a single critical care intervention. A single intervention if they are by themselves in the back. Will said that it would be limited to the arterial line and one critical care drug, right? Dr. Chizmar that it's just a single critical care intervention. Brian Ashby said that the way he read it that it's the critical care drug that we can run as a solo SCT paramedic, but it doesn't say anything about how we're going to monitor that patient. If you go with arterial line, then that's two interventions. Dr. Chizmar said that that protocol reiterates what's in the regulation. It's a single critical care intervention, which would be a med or an intervention. When we went through this, we were trying to pluck off the cases where a solo SCT medic could take the patient on their own. Somebody's that's intubated, on a vent, and on Levophed is more than one critical care intervention. You would need to have another person onboard. Will said so to Brian's concern, there'd be two people. So, you could have a SCT medic and a regular medic to monitor the vasopressin and the arterial line. You would still have two people in the back. Dr. Chizmar said that it's almost that. He thinks it's two SCT medics. There was some discussion about the second person and their level of training. Dr. Chizmar said yes, the second person, when you have more than one critical care intervention, that is what we need to look at because most people run it as an SCT/RN. Dr. Chizmar mentioned that some of Zach's questions revolve around a double SCT configuration and that this is where this question is coming from. Dr. Chizmar asked who brought up the arterial line discussion at the SCT meeting since he wasn't there for that part of it. Leigha McGuin answered that she brough it up.
Dr. Chizmar suggested to Brian that it might be good to connect offline with Leigha and anyone else who is interested and try to make sure he represents the discussion. Leigha asked if that can also include compression devices? Will said at this point it is all heading towards 2027 so they can bring anything forward to the PRC to review.

Old Business – Will Rosenberg –

Will Rosenberg asked if there was any Old Business.

Scott Legore reported that the protocol app went missing from the protocol app store for a week to 10 days. It has been restored. It should be back on the app store. If you do have issues with it, let us know so we can track it down again. Todd Abramowitz confirmed it was back in the app store.

New Business – Jimmy Pixton

Jimmy Pixton said this is unrelated to CASAC, but has to do with Blue Cross. Mark is on the call and they have been discussing Blue Cross. I don't know who in this meeting has anything to do with billing and that kind of stuff. He is going out of his way to get them on the phone. He said we all know that the Care First is the lowest payer of all the insurances. They keep screwing up claims after claims and claims. Mark at ProCare has taken a very aggressive approach and it seems to be working. He just wanted to mention that he is going after Blue Cross Blue Shield. He just wanted to know who else wanted to be involved because if he does to them as talking for 20 companies versus one company can change everything. We are basically still getting paid for the same rates today as we did back in 2003. If anyone cares, get a hold of him so it can be discussed. Anyone who deals with Blue Cross should care. They are denying claims, stating they don't get the claims, then they give you filing rules that we didn't agree to, and it's one thing after another. I wanted to bring it up because we can never get all these people from different companies together anywhere else. That's all he wanted to share.

Scott Legore said that we are working internally here at MIEMSS to try to put together some type of stretcher safety video. The thought process would be that we would roll it out to all new EMTs as part of the EMT training program with MFRI and other EMT training programs, with stuff like proper strapping and more. The ask of the group is if you already have some type of stretcher training video that you would be willing to share with us so that we could either bulk it up or maybe use a portion of it for our video, we would appreciate it. We are not looking to recreate the wheel here, but we believe commercial services are probably head and shoulders above the 911 service on strapping and stretcher safety. We are looking to get that out to try to enforce that safety. It's probably going to be a summer or fall project. We are just looking for some starting points if some folks already have some stuff.

Zach Risoldi said that Mr. Legore asked him to follow up with everyone about a vehicle fire they had several months ago and get some information out about it. They had a BLS unit that had the cab completely consumed by fire. They had some suspicions as to the cause. This was a 2024 Ford Transit and they had purchased it from the Miller Coach Company. They had recurring issues with the marker light overheating. This particular one in question was on the front bumper area. There are two other amber lights and they are not the only ones noticing that the LED housing is overheating dramatically to the point where it can melt plastic. They have reached out to the Miller Coach Company. They will not acknowledge liability in this issue, but they also indicated that this was not the first time they have heard of this. They currently have three or four other ambulances where we know this heat is a problem to the point that they have removed these marker lights from all of their units. They can't definitively say this was the cause of their vehicle fire, but that is their suspicion. They wanted to pass it along in case anyone's affected by Miller Coach.

Will Rosenberg asked if anyone else had New Business. No response.

For the Good of the Committee –

Will Rosenberg asked if there was anything else for The Good of the Committee. No response.

Adjournment

Meeting adjourned

Attendance:

In Person: Will Rosenberg, Scott Legore, Dr. Tim Chizmar, Aaron Edwards, Jim Pixton, and Jill Dannenfelser.

Virtual: Marty Johnson, Donna Geisel, Lara Snyder, Golden Days Representative online, Zach Risoldi, Sarah Pysell, Matt Larrabee, Mark Nellis, Matthew Kravetsky, Claire Pierson, Jonathan Siegel, Brian Ashby, Jeff Kreimer, Tyler Stroh, Mike Moretti, Kate Passow, Teddy Baldwin, Mike Herndon, Mark Buchholtz, Anna Gainor, Justin Webster, Leigha McGuin, Scott Barquin, Lando Orsino, John Pierce, Cyndy Wright-Johnson, Derek June, Rob Weiss, Brian Fletcher, Heidi Hubble, Hali Crist, Steve Rawheiser, Todd Abramovitz, and Justin Kram,

Callers: #01 – Brian Fletcher