CASAC Meeting
Minutes – September 16th, 2026

Meeting called to order by Chairman Rosenberg

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

State Medical Director's Report – Dr. Chizmar

Office of Integrity – Dr. Chizmar advised that Lisa Chervon will be out of the office for a short duration. During her time of absence Dr. Chizmar, Claire Pierson, and several others will be covering the Office of Integrity.

Heparin OSP – Dr. Chizmar discussed the potential change with the Heparin OSP and changing the maximum dose/rate. There is a conference in which they will be looking at the 2000 units per hour dosage. The dosage change may be a next year protocol change. He is looking to find out if the services have any input regarding this dosing and its change. Will Rosenberg said that the way the protocol is currently written confuses the dispatchers or whoever is assigned to answer the incoming phone calls for transport requesting involving heparin. The number of units per hour is very black and white and they haven't had any issues with it, but it could become a problem. Justin Kram added that the 2000 units an hour captures most the patient population that they are encountering. There would be a few outliers, like smaller patients. He added that there's not an insignificant bariatric patient population where we benefit from that expanded definition to include 18 units/kg an hour for the bariatric patient population. He would hate to lose that context, if possible. They have experienced some trouble in trying to explain the logic behind the dosage to both clinicians and dispatch personnel. Will asked Dr. Chizmar what's the significance of 18? Dr. Chizmar advised it is the commonly accepted dosing. You know that the way that you dose heparin is that you start at a place, check a PTT, and adjust the dose accordingly. So, in some cases people need to be on higher doses because they break the heparin down faster. Could we look at data and see what you guys (the services) are actually moving, because this may be a moot point. We may not even need some cap on the maximum dose. Dr. Chizmar cannot see all of their records. There was discussion everyone about when heparin was added into the protocols and safeguards that were put in place. Mike Gill spoke up about the heparin dosing and numbers. Those numbers indicate what type of unit is transporting this patient on Heparin and maybe we should not be letting a "number" determine the type of unit. Dr. Chizmar agreed and confirmed that he would like a little bit of data to base the decision on. He is willing to make a change to either increase the

cap or remove the cap altogether, but he needs more data. He is open for a change. He is asking that the services that use this OSP let us know what their cases have been recently. Will agreed and said he thinks that by October 1st the services should be able to provide that. If there are any services that thinks two weeks to pull that data is unreasonable, please speak up. Let's everybody try to air to get that data to Scott Legore by October 1st and he can get it over to Dr. Chizmar. Justin Kram asked specifically what data would you like, or how do want that data presented? Dr. Chizmar advised that a reasonable of case information is needed. If they look one year back at your patients that received heparin, advise what the dose was when you started the call. So, if you had 10 cases, what the 10 cases are, like the date of the case and what the dose of heparin was when you picked them up at the signing facility. Justin questioned one year. Dr. Chizmar advised if that's not too much to ask. Maybe six months is more reasonable? After some discussion, it was agreed that the services would provide heparin data for the past 6 months.

MMP OSP Organization – Dr. Chizmar turned the discussion over to Meg Stein and Mike Gill. He advised they have some ideas about pure protocol organization for interfacility sections of the protocols. Meg stated there are interfacility OSPs in the one section of the protocol book scattered through the OSP sections, and then there is the interfacility section of the protocol book. It is kind of confusing and if you are a clinician, you end up going back and forth looking through both sections. Meg turned the discussion over to Mike because it was really his idea to move the OSPs in with the other interfacility part of the protocol book so that it is all consolidated into one spot. Mike advised that when he train new medics that are coming into their service, there is section 13. New clinicians coming from out-of-state have a harder time with our protocol book than the in-state clinicians, but basically, we have information scattered all throughout the protocols. He went through all the protocols and printed off the information that applied to them, put it in a packet, and he gives it to them. He had the idea that we put everything into a section/chapter so the clinicians don't have to jump back and forth. Not rewriting any protocols, not adding any protocols, just consolidating what we have and put it all under interfacility. Dr. Chizmar thanked Mike for his idea. He pointed out that there are some protocols that are used by both 911 and interfacility. We could focus on the ones that are only used by interfacility; heparin is a great example. Another one is the prehospital antibiotics. I think it's a good idea to try to put all the information into an interfacility section and try to build it out so that it is more useable for all of your clinicians. There was discussion about how this change would look. There was general support for this change. Mike will work with Meg as we have time to make these changes and see how it looks. Mike thanked Dr. Chizmar for being open with this idea and letting them move forward.

SOCALR Report – Scott Legore

Inspection/License/Renewal Update – (Marty Johnson unavailable) - Scott Legore

We are getting close to the end of the inspection season. We have a couple of services with September renewal dates that are finishing up and the October renewal packets are out. We would like to remind the services again, please do not wait until the last minute to submit your paperwork and get on the schedule. Each month SOCALR is processing and inspecting several services. When you wait until the 15th or 20th of the month it can be a challenge on our end to schedule the inspections prior to the end of that month. Please submit your paperwork and preferred inspection dates as early as possible.

QA Review/Data Import – (Scott Barquin unavailable) - Scott Legore

Scott Barquin is working on QA reviews of data imports. You should be getting an automated monthly report for any unidentified clinicians that the system is showing. We are asking that you are proactive with this list and address it before it gets too long. We recently had a service whose report was 23 pages long. We need to prevent this from happening. You need to take action sooner than later to address these issues. It could only be one or two clinicians that are showing up on multiple calls that make the list, but once it is fixed, they go away. It's on the service to identify and correct these unidentified clinicians.

Smartsheet Update – Scott Legore

You should be aware by now that the Office of Integrity has switched over to an electronic version of the 5/35 – Day Incident Report. All services should have received notification on that information. There is also a dashboard that you can see your reports and their status as they are updated. One of the issues that they are having is that it requires the medical director to acknowledge the report. The last number was approximately 30% of the reports have been acknowledged by the medical director. So, please ensure that your medical director is aware of the process and that they are acknowledging these reports. Their acknowledgement takes the place of the medical director's signature that was on the report previously. It is kind of concerning that in the past the medical director's signature was on the form, maybe without his awareness, and now we are not seeing the compliance. But we are hoping that the services correct this situation as we work through it. As Dr. Chizmar mentioned, Lisa Chervon is out for a little while. So, there may be some changes on how we process some of those.

Dr. Chizmar – Real quick, I know that Lisa, Donna, and I discovered, at least on the 911 side that we had a few contact emails that were outdated potentially or there was a spelling error or type in the medical director's email and that would change his notifications. If you talk to your medical director and they are saying that they do not know what you are talking about or they are not receiving the notification, please reach back out to Donna so that we can see which email has

been recorded for the medical director. As Scott was saying, please go back to your medical directors and talk to them.

Donna Geisel – The trigger for the notification to be sent to your medical director is the email address that the QA Officer entered on the 5/35 – Day Incident Report. A lot of the medical directors have multiple email addresses, so you want to use the email that they are checking on a regular basis, and that may be a conversation to make sure that your medical director is seeing his emails. For example, your service may have an email address set up for him with your service that he might check once a week, but he might prefer to use the email address that he is using with his hospital or whichever email address he has set up with his phone. Please reach out to your medical directors and have a conversation about their preferred email address.

Leigha McGuin – I have some questions about the 5/35 – Day Incident Reports on Smartsheet. I am not receiving, as the operations leader, an automated response about submission. And, when I am going into the Smartsheet dashboard to look, I am not seeing all of the incidents despite trying to filter through.

Donna Geisel – So we can work with you on those items. There's a couple of things going on in the background. First, the operations managers are not set up to get notified. It's just the QA Officer, and then the Medical Director for his verification. The other part of that, not all of them showing up, is that we are trying to work through a process. If it's not a clinician issue, the Office of Integrity forwards it to SOCALR. That forwarding process is currently removing the reports from your dashboard. We are trying to add another widget so you can continue to see those, but there is background stuff in Smartsheet that we have to develop first for that information to show up. In essence, if the Office of Integrity has decided it is not a clinician issue, they forward it to SOCALR as a service-related issue, if that makes sense.

Leigha McGuin – If you have a suggestion box, I would hope in the future that the leadership could perhaps get on an automated list, because out of sight for me is out of mind. I am going to lose visibility and that's what I don't want to do.

Donna Geisel – With that being said, when we set up the automations and the leadership gets those, it creates multiple emails: when the 5/35 – Day Incident Report comes in, when the generated document is created, when an update is created, and so on. What we have discovered is that you get so many automated emails is that they get lost and you start ignoring them anyway. We have to figure out a way to reduce the number of emails that the leadership would receive. Right now, it is set up so that the QA Officer gets notified.

Leigha McGuin – My final question if for the medical director. They receive the automated emails for verification, but what if our primary medical director is out? Is there a way to delegate that role to someone else to receive in their absence?

Donna Geisel – The automations are set up to go to whoever is entered into the 5/35 – Day Incident Report and they are made aware of that 5/35. So, in your case, if Dr. Lawner was the one who was involved in that 5/35, that's the email address that should be entered and triggered. If it's your associate, Dr. Nusbaum, his email address should be entered. The automation is not set up for multiple doctors' email addresses to be entered. Manually I can override that and create an automation. So, if your primary medical director gets notified and then tomorrow, he goes out of the area for a couple of weeks, I can manually go in and force an automation to go to your associate medical director. But the service would need to let me know that the manual notification needs to be completed.

Clinician Services – Aaron Edwards

Aaron Edwards advised they had about 2,000 EMT renewals and the median renewal processing time was three days. Psychomotor testing year to date: They administered testing at 122 different test sites, totaling around 1,983 students. Some of those would be ones that needed to be retested. Reciprocity year-to-date is 464, with their license issued within an average of 12 days. 10 of those days were waiting on the protocol orientation. We have about 3,000 clinicians set to expire in January. On another note, we have a few educational programs that have not sent in annual reports. There was discussion about reaching out to several of the programs. Aaron reached out on September 6th. A couple of them will be expiring in November. Scott advised he can reach out to several of them. Will asked if anyone had questions for Clinician Services. There were no questions.

Committee Reports

PEMAC Report – Jill Dannenfelser (unavailable)

Scott Legore mentioned that they did have a discussion on the antimicrobials and adding pediatrics, and that information has been sent out. They have created a pediatric newly born reference sheet which is a two-page sheet that you can print and put in your units if you transport newborns. It's pretty detailed. It's out and available.

SEMSAC Report – Danny Platt (unavailable) Teddy Baldwin advised nothing new to report.

MIH Report – Deb Ailiff (unavailable) Mark Buchholtz advised nothing new to report.

Old Business – Will Rosenberg

Will Rosenberg asked if there was any old business. No old business to discuss.

New Business – Will Rosenberg

Some new business was covered earlier in Dr. Chizmar's report. Will Rosenberg asked if there was any other new business. No other new business to discuss.

For the Good of the Committee – Will Rosenberg

Jim Pixton questioned if CASAC were having elections this year. They asked Scott Legore if there were elections this year and he thought the elections were to be held next year, but he will double-check. Jim Pixton advised that he is asking because he is the co-chair and there may be a conflict of interest. Will Rosenberg spoke up to state that Jimmy is referring to the purchase of Am-Van, also known as All American Ambulance, by his parent company, WLRC Medical. Per the bylaws, Mr. Pixton can no longer be the vice chair or co-chair because of a distinct conflict of interest. So, we will have to address that in the next meeting if everyone is okay with that. We will have a special election. So, if you are interested in the vice chair, please submit your resume or CV to Scott Legore and he'll disseminate it.

Adjournment – Will Rosenberg

Leigha McGuin made a motion for the meeting to adjourn. Meeting adjourned.

Attendance:

In Person:	Will Rosenberg, Scott Legore, Dr. Tim Chizmar, Aaron Edwards, Claire Pierson, and Donna Geisel.	
Virtual:	Owen Siford, Lara Snyder, Jim Pixton, Jonathan Siegel, Bobby Harsh, Jeff Kreimer, Justin Kram, Meg Stein, Danielle Telesford, Mark Buchholtz, Tyler Stroh, Teddy Baldwin, John Pierce, Anna Gainor, Donny DeGraves, Leigha McGuin, Brian Fletcher, Mike Moroetti, Steven Rawheiser, Abby Butler, Hali Crist, Justin Webster, Randy Linthicum, Mark Nellis, and Zach Risoldi.	
Callers:	#1	Mike Gill (MedStar)
	#2	Jimmy Harsh
	#3	Matt Larrabee