# Region IV EMS Advisory Council

**Chris Truitt, Chair**
**Chris Shaffer, Vice-Chair**
**KJ Marvel, Secretary**

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## AGENDA
## March 18, 2025

1. Call to Order & Introductions
2. Approval of Minutes
3. Regional Medical Director's Report
4. Pediatric Medical Director's/EMSC Report
5. EMS Board Report
6. SEMSAC
7. Regional Affairs Report
8. Mobile Integrated Health Programs
9. MIEMSS Report
8. Agency/Regional Reports
9. Old Business
10. New Business
11. Adjournment

Next meeting
May 20, 2025
@ 1330 hrs.
605 Port Street
Easton, MD 21601

**REGION IV EMS ADVISORY COUNCIL**
**March 18, 2025**
**Minutes**

**Attendees:**

**In Person:** Chris Shaffer, Bryan Ebling, Michael Parsons, Joel Dixon, John Dennis, Shari Donoway, Tina Kintop, Dr. Chiccone, Dr. Chizmar, Kathy Jo Marvel, Zach Yerkie, Scott Haas, Dr. White, Cyndy Wright-Johnson.

**Virtual:** Mark Bilger, Lorenzo Cropper, Emma Dittoe, Doug Walters, Danny Tyndall, Nicole Leonard, Randy Linthicum, Yelitza Davis-Hernandez, Logan Quinn, Aaron Edwards, Dwayne Kitis, Sgt. Jonathan King, Bobbie Jo Trossbach, Falon Beck, Morganne Castiglione.

The meeting was called to order at 1:30 pm. by Vice Chair Chris Shaffer

**Approval of Minutes:** A motion was made by Kathy Jo Marvel to approve the January 21, 2025 minutes as written, seconded by Zach Yerkie and passed.

**Regional Medical Director's Report:**

**Dr. Chiccone** – I have a few announcements from our Medical Director's call. The EMS Board met recently and Dr. Chizmar announced that the Emergency Department Advisory System (EDAS) which is going to replace CHATS is just about ready to go live with May 1st as the rollout date.

There was also an announcement about measles being present and circulating in Maryland. There is available information and clinical updates about this on the MIEMSS website.

At our most recent Region IV meeting, three chiefs from our region had voiced a concern that some of their interactions involving dual consultations had room for improvement. I asked them if they would submit the specifics to me which they did. Based on a recommendation by Dr. Chizmar, I forwarded what I received from the chiefs to Dr. Jen Anders. Dr. Anders incorporated those suggestions in the rollout of what is going to become the Pediatric Decision Tree 2.0 best referred to as a decision support tool.

Dr. Anders wants to do two things:

- She wants to identify in the portion of the protocols called Critically Unstable Pediatric Patients an expanded definition with some specific recommendations regarding respiratory illnesses.
- At the suggestion of Dr. Levy, she also wants to give some indication of stay and play versus load and go with regard to both medical and trauma patients in the pediatric age group.

Regarding the Decision Tree, the goal is to try to stratify the resources that are available to us in the state and in the surrounding areas of the state in a plan that will be approximately as follows:

A pediatric ready emergency department would be defined as a department which is capable of stabilizing and readying for transfer, if necessary, any pediatric emergency patient. Dr. Anders envisions that this would include all the emergency departments within the state as well as all sanctioned freestanding emergency departments.

There would be a second level referred to as a pediatric resource hospital. What would distinguish that level would be the capability to have overnight observation and or inpatient admission for pediatric patients.

There would be a third designation currently being referred to as a comprehensive pediatric center. What would distinguish those centers is that they would need to have pediatric intensive care and be OR capable for the pediatric patient population.

This will be coming as soon as information is agreed upon. Cyndy; would you like to provide additional clarification?

**Cyndy Wright Johnson** – Yes, the EMS Board has approved those three levels and the hospitals will have an opportunity starting in April to apply for those. I think we all know where the Pediatric ICUs are, but the hospitals will be able to come in as Peds ready or Peds resource. It is very clear in the grids that we have been sharing with the nurses and physicians where they would fall.

**Dr. Chiccone** – The Chiefs were invited to sit in on that protocol review committee and thanks to you and your submissions, Dr. Anders was able to take your suggestions about consultations back to the Base Stations for recommendations to the people that are answering the radio.

At the protocol review committee, the Hypertensive Disorder protocol came back for a second visit trying to drill down on some more specifics maybe to set some limits for blood pressures.

We did make some significant progress about what would be allowable administrations of drugs with and without consultation and what would be the ceiling doses for those drugs. Dr. Chizmar did conduct a poll at the meeting advising everyone about the difficulties that will emerge regarding in particular diltiazem. Some forms of the medication will be only viable long-term if refrigerated and others will expire within a month. So, a poll was taken about what should happen with other drugs like Verapamil, Metoprolol and Esmolol etc. and we were able to get that feedback passed and the official recommendations will be forthcoming.

**Pediatric Medical Director's/EMSC Report:**

**Dr. White** – We had the Medical Advisory Committee meeting on March 5th where we did discuss the protocol issues with the critically unstable pediatric patients. We do not want to move unstable pediatric patients before they have been stabilized recognizing that unstable pediatric patients are often comprised of respiratory problems and sepsis and less likely primary cardiac. So, obtaining an EKG is less stressed than it would be obtaining that on adult patients. However, we still want to minimize movement until they can be stabilized. There was a lot of discussion

about the pediatric decision tree and the ED categorizations. I agree with Dr. Anders that every facility should be able to stabilize pediatric patients. These facilities have well-trained and staffed EDs including the freestanding centers; so, just knowing what those capabilities are will be helpful for EMS clinicians.

We had an ED simulation pilot on February 21st that I attended at TidalHealth Regional. They are working on some robust simulation cases to train EMS clinicians, nurses and physicians. They did a combined simulation starting with EMS and proceeding to the ED and it was a really good session and helped both sides to understand their colleagues in their perspective professions.

**Cindy Wright Johnson** – I am coming from a joint meeting of your Pediatric EMS Champions and your Pediatric Nurse ED Champions and unfortunately only nurses from Shore Health physically attended the meeting. I can only assume this was due to schedule changes. We also had two EMS Pediatric Champions who have been very involved for a number of years pulled back because of budgets and that was a disappointment. The meeting was incredibly helpful, Doug Walters spoke in great detail about the simulation at THRMC that Dr. White mentioned in his report. The Champions from both communities, EMS and emergency departments, would like to do that simulation in more of the jurisdictions. We are probably going to need to combine a couple of those simulations and Doug Walters was willing to take the lead on that. They also want to do quarterly case reviews; they want to learn about significant cases from other jurisdictions and other emergency departments. They talked about two recent drownings and two significant motor vehicle crashes where children had to be stabilized in the hospital, and then transferred out to a pediatric trauma center. So, I think they have the four cases they want review throughout 2025 and they would like to make it available to the Region.

We have simplified Right Care When It Counts so that it is no longer 10 criteria on a green chalkboard, it is 5 criteria in a certification frame. I'm afraid in doing that people aren't recognizing it. I have zero children who have been nominated from across the state and we usually at this point have eight to ten nominees. So please go back and think about a child that did something to activate your system, a child or youth who helped somebody, recognized an emergency, or a youth who intervened.

Although unrelated to EMSC, I would like to note that over half of the Star of Life awards have no nominations. Also, I know from a meeting that more than 80% of the MSFA awards that are due in April for June convention have no nominations.

**EMS Board Report:**

No Report.

**SEMSAC Report:**

**Scott Haas** – Everyone should have received my SEMSAC report that was emailed out and I would be happy to take any questions.

I do have a request for the Region IV office. Could someone check with headquarters to see where the SEMSAC presentations are posted on the MIEMSS website? I've been told that they post the presentations under the Minutes and Agendas tab, however I cannot seem to locate them.

**Regional Affairs Report:**

**Dwayne Kitis** – We went over the 2024 grants and there is only a few of those still outstanding. We also went over the 2025 grants and everybody has their agreements. We are waiting on a few PO's and we will be following up on those.

I did want to announce that Dave Chisolm is going to take over the significant hole left behind by our dear friend Rick Koch.

**MIEMSS Report:**

**Dr. Chizmar** – One of the things we are looking at is removing Verapamil, which has been a backup drug that not many people like to use because it causes hypotension and putting metoprolol in there as the backup medication for A-FIB.

A shortage of amiodarone has been reported by several of the large counties. To help address that we are going to bring back lidocaine. So, what that means is the Lidocaine Pharmacology page will be coming back with the cardiac indications on it as well as the reasons we are using it. We are not going to change the protocol to remove amiodarone, however if you feel the effects of the amiodarone shortage, lidocaine will be there as a backup.

During the Medical Director's call, we talked about some of the legislative bills we are following. This is just my synopsis of what I know today, however it could likely be outdated by tomorrow.

- House Bill 935, which requires all school systems to have medical personnel on scene for high school football events. This bill puts the onus on the school system to have a venue specific emergency plan that would have either an athletic trainer, an EMS clinician, a physician or a nurse or a trained school system employee present with an AED and limited medical equipment at high school football games. Again, it's not a requirement on EMS, it's a requirement for school systems to have this venue specific emergency plan, which includes having a healthcare professional staffing the high school football event.

- Senate Bill 205 is a bill that formally adds us to the list of mandatory reporters for vulnerable adults who are experiencing abuse or suspected abuse. The reality is it has

been in the protocol for many years to report child and vulnerable adult abuse, but it turns out there was a loophole and we were not actually required to report vulnerable adults only children who are experiencing abuse. We would like to delay the official onset of this bill until October of 2026 to make sure that we are able to provide appropriate education. Dr. Delbridge also wanted to emphasize that the reporting requirement could be met by calling a statewide hotline as opposed to filling out a bunch of complex paperwork. So, our goal with EMS is to have it in the bill that they could call the abuse hotline and that would satisfy the reporting requirement.

- Senate Bill 1023 is an employment bill. It does not affect MIEMSS, at least as far as the attorneys have told us, however it could affect many of you. It is the cannabis bill and it is my understanding that it makes it unlawful for employers to discriminate against firefighters and emergency medical service personnel who are prescribed and use medical cannabis as long as there's a gap of 12 hours from the last time they used it and they show no signs of impairment coming to the job site. Everyone should have received compliance or office of integrity information on where MIEMSS stands. If you discover through whatever process a person is impaired and they test positive for cannabis or any other drug we will still take those cases on. What we cannot take on are random drug tests where someone randomly tested positive for cannabis with no signs of impairment. According to the attorneys, this bill doesn't affect the licensure process, but it could affect your employment processes.

- House Bill 1131 started out as a bill that would have required buprenorphine to be on every ambulance in the state. We worked with the bill sponsor very early on to try to ramp this down into something a little bit more reasonable. In its current form, it would provide a grant of around $50,000 to provide buprenorphine training so that more paramedics have the knowledge to initiate buprenorphine. So, it would not be a mandate as it was originally intended, it would provide funding for us to do additional buprenorphine education in addition to what is being done through MIH. They also wanted it to be administered at every level of EMS certification. We pushed back on that believing that this is still a controlled substance and the administration of buprenorphine should be done only on a paramedic level skill.

- Senate Bill 369 is a bill that would require an AED in all public Libraries. After reviewing the CARES data, I cannot say that the proportion of cardiac arrests in public libraries is large.

**Arron Edwards** – We are in the end of the recertification of paramedics coming up at the end of the month. Most of them will have their National Registry and I guess the onslaught will happen right after that.

**Bryan Ebling** – I have a few items that I would like to report out on.

1. **ELITE Single Service Conversion**

- Region IV Office and EMS Applications Administrator Jason Cantera met with the Worcester County HJO and discussed needed items from the jurisdiction to move the project forward. The next meeting is scheduled for April 14th at 10am.

- Somerset County requested to move to a single service within the ELITE system and we are working with them to accomplish that as well.

2. **ALS Education Grant Discussion**

- Award letters are coming out of the finance office. If you do not have yours yet, please keep an eye out and return it promptly. Once you receive your purchase order you can request reimbursement.

3. **Cardiac Device Grant**

- FY2024 Grant – Please be sure to submit for reimbursement after the equipment has been received. This must be submitted by June 15, 2025.

- FY2025 Grant – All award letters should have been received. If you are a recipient, please assure you have a purchase order. Once you receive the device, please pay the invoice promptly and file for reimbursement as soon as possible. Keep in mind we want to close the grants out by May 30, 2025.

4. **VAIP**

- Congratulations to Dorchester County DES, Dorchester County Volunteer Departments, Caroline County DES and Ridgely Volunteer Fire Department for passing their VAIP.
- The next statewide VAIP meeting is scheduled for March 26, 2025 at 2:00 pm via Google meet.

5. **Hospital Preparedness Programs**

- Reminder of the Medical Surge and Response Exercise is being held on May 13, 2025 at 9:00am. We are asking all 11 EMSOP's to participate.

6. **Training Opportunities**

- First responder Wellness and Mental Health Conference will be held in Ocean City on March 24th and 25th.
- EMT Skills (12 hr.) – MFRI Upper Shore on May 17, 2025

- EMT Refresher – MFRI – Girdletree VFC May 3, 2025
- Prehospital Trauma Life Support – Cecil County - MFRI – March 22, 2025
- Emergency Pediatric Care – Easton VFD – MFRI – May 1, 2025
- Maryland Rescue Task Force for EMS – Easton – MFRI – May 3, 2025

**MIH:**

**Caroline County:**

**Kathy Jo Marvel** – We are working with Tetra Tech who is helping us write our policies and procedures. Hopefully in July we will see the Mobile Integrated Health program begin to take shape.

**Cecil County:**

No report.

**Queen Anne's County:**

**Zach Yerkie** – Brice Strang is our new Health Officer in Queen Annes County and we will be meeting with him this month. Dr. Ciotola is still somewhat connected to the health department because they need a physician to oversee their clinical programs.

On the state level there was some discussion at a recent meeting that was held regarding the role of CRTs in MIH. There was a motion that came out of that meeting and it was sent up to SEMSAC for their review. There was a discussion about how to potentially bring on EMTs in a standalone role, however the committee wants to prioritize figuring out the overall educational requirements of MIH clinicians first.

**Salisbury:**

**John Dennis** – We have our Buprenorphine program up and running and it is currently operating Monday through Friday 8 to 4:30. The goal is to expand to 24/7 availability, but we're not there yet.

On January 1, 2025 we launched the Safe Initiative which is swift assessment of falls in the elderly. They've contacted over 100 people and 45 home safety assessments have been completed. They have drawn around 20 vitamin D levels and they have seen about a 75% acceptance rate, meaning most individuals allow us to return to for home safety assessment and backup vitamin D lab draws. The program has demonstrated a 97% success rate with no repeat falls within 30 days of the intervention.

Lastly, David Phippin, the coordinator for our Swift / MIH program, is retiring and we are hopeful to name his replacement soon.

**Talbot County:**

**Tina Kintop** – We are always looking for different kind of referral streams other than our 911 calls. We are a part of the HERC (Health Equities Resource Communities) grant with the Talbot County Health Department which has been a little challenging due to changes within the health department and the changing of requirements that the grant facilitators wanted reported. We are also introducing our program to the police departments just so they know what we are looking for since they get dispatched on basically the same kind of calls where people may need assistance as EMS does.

**Agency Reports:**

**Salisbury:**

**John Dennis** – The Salisbury Fire Department is making steady progress towards implementing a whole blood administration in the prehospital setting. We met with a representative within the last week or so about supplies and cost. This morning, we found out that it sounds like PRMC TidalHealth is actually going to cover most of the cost for the program.

We recently met with Bound Tree to explore different options for our current video laryngoscopes. Currently we use Airtraq, however we are looking at going with a different brand.

Our local 911 center has recently upgraded its CAD system and we have experienced some growing pains, but they've been working really hard this week and I think we are almost 100% now.

**Old Business:**

**Scott Haas** – So, the current bylaws committee, Zach and myself, spent the other day going through the current bylaws and highlighting the following proposed changes;

- Article III Region Served – Do we still need to subdivide the counties into three separate areas since the grant funds are no longer subdivided? (Remove)

- Article IV Representation - Do the 911 Centers, Commercial ambulance services and MFRI need to stay on as a mandatory representative at the Council Meetings? (Remove)

- Article XVII Committees – Section B Standing Committees – Educational Committee – Leave in as written.

- Article XVII Committees – Section B Standing Committees – Ambulance Strike Team Committee – Leave in as written.

The bylaws will be updated to reflect the above changes and voted on at the next council meeting.

**New Business:**

**Dr. Chiccone** – This item would be addressed to the Medical Directors and Chiefs and it is in regard to your Quality Assurance / Improvement Plans in particular your conduct of Medical Review Committees (MRC's).

I would like to make the following proposal:

- If any of you currently have in your plan that the subject of an MRC can appeal to the Regional Medical Director, please make sure they are restricted to process violations. The reason is that displeasure or disappointment with the outcome of an MRC does not constitute grounds for an appeal to the Regional Medical Director. I do not have a MIEMSS obligation to hear appeals except for process violations. So, for those of you who do have plans, please look again at the appeals process and be sure that they are restricted to process violations.

**Adjournment:** The meeting was adjourned at 2:59 pm.