Meeting was called to order at 1300 hours by Chair Bill Dousa. He thanked Hollywood Rescue Squad for lunch. President Stanley Williams welcomed everyone.

Linda Dousa passed around the sign in sheet and asked everyone to verify that the information is correct.

Chair report: Bill Dousa asked for approval of the minutes from the March 5 meeting. Motion by Susan Mott, second by Russ Zaccari to approve the minutes. Motion carried. He welcomed everyone for the New Year. Wayne Tome is now the MSFA branch director for EMS.

Association Officers: Second Vice President Rick Blair introduced himself and welcomed everyone. He also stated several Executive Committee members are present today; Wayne Tome, Charlie Simpson, Dan Stevens, Johnie Roth.

Past president Johnie Roth gave an update from the committee looking at the EMT testing issues. They have not met since before the Convention but will meet in the near future to discuss the progress for the current classes. The numbers seem to be improving above the National Registry and are significantly better than previous classes. MFRI is starting a pilot program for EMT that reduces the number of module tests during the class allowing for increased instructional time; this seems to be working well. Montgomery County has already adopted this new system; MFRI stated they have also since the pilots are completed and worked well. There is still question of whether MIEMSS will continue to pay for a student who has taken the National Registry and failed as well as questions about the continuation of prep classes. Charlie Wills asked how long, from beginning to end, a current EMT class is. The class is advertised as 165 classroom hours, but with My Brady Lab and other study times, it’s nearly double that amount. There was discussion of the computer adaptive testing and the fact that some students will not be able to pass the test. In order to get as many students to pass, companies need to support and mentor them, which led into a discussion of developing the capability and measure to do this. Many experienced providers have not completed computer adaptive testing and want to know how they can be updated so they can mentor students. There was a request to get some sort of tutorial for training officers and field coaches. There has been a change to make the delay between training and testing shorter; students initially had to pass their practical before they were eligible to sit for the written. Now, once they have passed the class and received their letter, they can sit for the written prior to passing the practical. Eric Smothers discussed the testing process and the number of questions the student may see. He also discussed the challenge of getting into testing sites; many of our students work during the day and many of the testing sites are open only during the day. Susan Mott discussed the original students who could not pass the National Registry being given EMR cards. She stated there are several in her company who cannot pass and wonder why they haven’t
been given the same opportunity. Dr. Alcorta stated the giving of EMR cards to the original students was a one-time offer to resolve a crisis situation. MIEMSS has adopted the process necessary to help make students successful. Sue Kay Ford asked if those given EMR cards will be EMRs forever. They must go through a refresher course every 3 years in order to retain their certification. Dan Stevens stated MFRI has purchased a Platinum Education test bank that gives feedback on weak areas to the students. This test bank will be available for all students who have successfully completed the EMT class and have not passed the National Registry. They will have unlimited access to this program for 1 year. The details are still being completed and regional coordinators should have the information soon. MIEMSS has spent over $120,000.00 improving the process. Charlie Wills stated “We are in crisis” and nobody can answer his questions. Dr. Alcorta stated that MIEMSS is working to make the process better and are moving forward. Wayne Tome stated the perception in the field is that MIEMSS went to National Registry testing to save money. He would like to see the numbers for the current classes. Dr. Alcorta stated the numbers of licensed EMT’s in Maryland are increasing yearly after a dip in 2014, which is when the changeover to National Registry testing occurred.

SEMSAC:
Linda Dousa stated there has been no meeting since May. Chair Roland Berg has retired from PG County and has resigned as chair. Jim Scheulin is current chair. The next meeting will be held on September 1.

ALS Sub Committee:
Marianne Warehime stated they did not have a meeting. The counties are coming up on the ALS refreshers; she would like to know if this year will be a disaster with the hybrid program. The online process was very difficult to deal with. Steve Frye feels like the process is gradually improving. Based on feedback, it doesn’t to be the same issues.

BLS Sub Committee:
Joan Williams welcomed everyone to Southern Maryland. She stated she has decided to resign from the committee as well as the BLS chair. She was thanked for her many years of service.

Standards:
John Sullivan has been out of service and has not obtained any information from Standards.

VAIP / Minimum Ambulance Standards:
Charlie Simpson stated there has been no meeting.

MIEMSS:
Dr. Alcorta: Handed out 3 documents.
• The Protocol verification document should be sent out and circulated widely. There will be no republication of protocols based on these verifications. Most changes are
typographical; there are a few dosing changes. Amiodarone, or Magnesium Sulfate can be diluted in NS, LR or D5W in 100 cc bags.

- The National Registry continued competency program document shows that requirements for Paramedic has been dropped from 72 to 60 hours for Paramedic (not changed for I99’s since they will be phased out in the future). He asked instructors to make sure they look over the breakout for training. One challenge will be research hours. They are looking at options. There was a question about BLS epinephrine administration and will EMT instructors be taught this. Dr. Alcorta stated there is a standardized training program available for this from the Office of the Medical Director at MIEMSS.

- He then hit the important points from the MIEMSS Executive Director’s Report. MIEMSS licensure – MPPR is a home grown tool that is antiquated. They have purchased an electronic tool that is going live. It’s much more efficient. When the Elite platform goes live, the two programs will be linked. This will make things more accurate in both systems. Elite migration – has been changed from December 1 to sometime in the late Spring / early Summer 2017 because of incomplete elements and support for all programs. He met with NEMSIS representatives and there are no penalties for this delay. There are several other states in this same condition. CARES – 22 of 24 EMSOPs and their hospitals are submitting data. By December, all jurisdictions and all hospitals will be operational. High performance CPR is making a positive difference in numbers of successful resuscitations. Legislation passed last year that allows for the hospital conversion to free standing emergency departments; MSFA did not support this but MIEMSS had to support because the EMS board became a reviewing factor for any downgrade request. Discussions have been underway pertaining to Harford Memorial Hospital, Laurel Regional Hospital and Chester River Hospital. He feels this is a sentinel alarm for all and will be working with MSFA. The central EMRC complex has been upgraded and MIEMSS is now working on the system digital upgrade. Mobile integrated community health – the pilot program in Queen Anne’s County was a success. They reduced transports by a large margin as well as identified multiple safety health risks. Charles County has received a grant and is looking at doing the same type of program. MIEMSS will be surveying jurisdictions for interest and gaps where MICH could help. The SEMSAC MICH subcommittee is looking at expanded scope of practice and alternate destinations (with minimum standards). Cardiac Arrest steering committee – looking at reducing time from call to hands on the chest in dispatch centers. Many of our PSAP have not moved to Medical Priority Dispatch version 13 (EMD).

**Dr. Seaman** is on vacation.

**MFRI:**

**Steve Frye** – ALS. He will be retiring as full time faculty in a couple of weeks. He will be working on a few projects. He thanked everyone for the many years of work. They are looking for people; all 3 ALS coordinator positions are now vacant. The search process is in progress. He will be coordinating the EMS leadership symposium. Dates are November 11, 12 (Friday, Saturday).
Todd Dyche - BLS. Dan Stevens standing in. He thanked Johnie Roth for his ongoing efforts with the EMT testing issues. Their strategic plan is being implemented and has adjusted class minimums; new grading system that give feedback to students and instructors; new LMS; electronic tablets in regions for EMT students, new electronic registration system. Fire act grants have been awarded to MFRI for the last 3 years. No EMS equipment has been purchased so far. If something is identified, let them know. Todd wanted him to report the EMT and EMR curriculum has been revised and have dropped some of the module testing. This will free up some hours for practical training. He again discussed the Platinum program for unlimited testing that mirrors the National Registry testing that will be available for all students that have passed the class but have not passed the National Registry. This will be available for 1 year. EMR has moved to incorporate My Brady Lab into the training.

MSP aviation:
Sgt Nathan Wheelock was present. Flight training device is still under construction and should be delivered in late Fall. The training building needs to have an elevator so construction has been delayed. Master service agreement RFP for heavy maintenance on aircraft for 5 years came back in August. This will be going to the Board of Public Works for approval. Chris St John asked about the hiring campaign MSP is doing. He discussed the process to include a seminar being done by a flight medic to answer questions. He was asked about the Trooper 1 move to Harford County; he didn’t have details and stated it’s in the hands of the politicians. The data shows it would be a successful and worthwhile effort.

RAC Shock Trauma:
Diana Clapp – 2 trauma technicians (Lauren Carr and Damien Hendrix) will be helping her with training for EMS. They can be reached at stcems@umm.edu. Observers are welcome to come to Shock Trauma. Let her know.

Old Business: nothing.

New Business: Wayne Tome stated he’s MSFA Branch Director for EMS. He needs a backup.

Good of the committee: Jeana Panerella stated the son of the Frederick County instructor is doing much better. He starts school next week. Eric Smothers stated highway grants should be coming back to the regions. Active assailant was the emphasis this year. If jurisdictions haven’t begun to plan, they need to.

Next meeting will be held on September 25 at location TBD.

Adjourned at 1450.

Respectfully submitted
Linda Dousa
TO: EMS Providers
    Highest EMS Officials
    Medical Directors

FROM: Richard Alcorta, M.D.
    State EMS Medical Director

DATE: June 14, 2016

RE: MIEMSS Clarification Documentation for 2016 Maryland Medical Protocols for EMS Providers

MIEMSS has received several requests for clarification regarding the 2016 *Maryland Medical Protocols for Emergency Medical Services Providers*, as there have been significant revisions in this year’s protocols. MIEMSS and the Office of the EMS Medical Director are very thankful for the thoughtful and constructive comments and clarification requests and have been diligently reviewing the protocols to address these issues.

In order to update the protocol in a timely fashion, the following revisions and clarifications will apply to the *Maryland Medical Protocols for Emergency Medical Services Providers* that are effective on July 1, 2016.

Please note that changes and additions are identified with *bold-italic* font and removals are established with a strike through. References to the applicable page(s) in the Full Version (including spiral-bound edition) and the Pocket Protocol are also noted.

   (2) Patients **12–13 years** of age or older:
   (a) If pulse is absent, use AED/manual defibrillator or begin CPR.
   (b) If pulse is present, continue assessment.

- G. Communications (p.36 Full Version, p. 12 Pocket Protocol): The following ALERT and entry were omitted but are still in effect.

  *(ALERT) ON-LINE MEDICAL CONSULTATION MAY BE OBTAINED AT ANY TIME FOR ANY PATIENT, IF DESIRED BY THE PREHOSPITAL EMS PROVIDER. PEDIATRIC AND SPECIALTY CONSULTATION IS ENCOURAGED FOR TRAUMA AND MEDICAL PATIENTS. CONSULTATION WITH PEDIATRIC AND SPECIALTY CENTERS SHALL OCCUR SIMULTANEOUSLY WITH A BASE STATION CONSULT.*

  5. If medical consultation is genuinely unavailable, or if the time necessary to initiate
consultation significantly compromises patient care, the provider shall proceed with additional protocol directed care, so long as transport will not be significantly delayed. “Exceptional Call” must be indicated on the Patient Care Report (PCR).

- K. Documentation (P.39 Full Version, P.12 Pocket Protocol): This edit will align current protocol with the applicable section of COMAR.
  A Patient Care Report (PCR) will be completed and delivered to the receiving facility as soon as possible, ideally upon transfer of care. If this is not immediately possible, providers must provide documentation of the patient’s prehospital care on a template and in a format provided or approved by MIEMSS for inclusion in the patient care record before leaving the receiving facility, then deliver the completed PCR within 24 hours after transfer of care dispatch, in compliance with COMAR 30.03.04.04

- Altered Mental Status: Seizures (p.45 Full Version, p.19 Pocket Protocol): The following guidance was added.
  - m) If patient is pregnant, actively seizing, consider magnesium sulfate 4 grams IV/IO over 10 minutes.
  [The paragraph level lettering for “m, n, and o” will become “n, o, and p.”]

- Altered Mental Status: Unresponsive Person (p. 47 Full Version, p. 20 Pocket Protocol): An age was changed.
  - m) If patient has respiratory depression with decreased LOC, constricted pupils, and provider suspects an opioid/narcotic overdose, Administer naloxone 28 days to 4 years (NEW ’16): Administer naloxone 0.8–1 mg intranasal atomizer (Divide administration of the dose equally between the nares to a maximum of 1 mL per nare.)
  - < 5 years to adult (NEW ’16): Administer naloxone 2 mg intranasal atomizer (Divide administration of the dose equally between the nares to a maximum of 1 mL per nare.)

- Pediatric Tachycardia Algorithm (p. 62 Full Version, p. 33 Pocket Protocol): A footnote was added.
  - (g) If Torsades de Pointes, administer magnesium sulfate (25 mg/kg IV/IO to a maximum of 2 grams over 2 minutes).

- Pediatric Cardiac Arrest Algorithm (p. 65 Full Version, p. 36 Pocket Protocol): A footnote was added.
  - (f) If Torsades de Pointes, administer magnesium sulfate (25 mg/kg IV/IO to a maximum of 2 grams over two minutes before amiodarone).


3. **Treatment**
   
   a) Assist patient experiencing moderate to severe symptoms or mild symptoms with a history of life-threatening allergic reaction with the patient’s prescribed or EMS service’s epinephrine **auto-injector or manual** (1:1,000) 0.5 mg in 0.5 mL IM or patient’s prescribed fast-acting bronchodilator.
   
   b) Consider additional doses of epinephrine (1:1,000) 0.5 mg in 0.5 mL IM.

**PP.** Respiratory Distress: ASTHMA/COPD (p. 139-140 Full Version, p. 84-85 Pocket Protocol):

Multiple changes were made; see below.

3. **Treatment**
   
   b) (MC) Use of the EMS service’s **manual** epinephrine (1:1,000) 0.3 0.5 mg in 0.3 0.5 mL or **0.3 mg via epinephrine auto-injector** IM requires medical consultation.¹
   
   c) Albuterol inhaler (2 puffs) may be repeated once within 30 minutes.
   
   d) (MC) Consider additional doses of patient’s prescribed fast-acting bronchodilator or **manual** epinephrine (1:1,000) 0.3 0.5 mg in 0.3 0.5 mL or **0.3 mg via epinephrine auto-injector** IM.
   
   j) Consider the administration of epinephrine 1:1,000.
   
   0.01 mg/kg IM
   
   Maximum single dose 0.5 mg
   
   **0.3 mg IM in the lateral thigh via epinephrine auto-injector or 0.5 mg in 0.5 mL IM**
   
   May repeat every 5 minutes for a total of 3 doses for severe reactions.
   
   m) (MC) For moderate to severe exacerbations, consider the administration of magnesium sulfate 1–2 grams in 50–100 mL Lactated Ringer’s or D5W IV/IO over 10–20 minutes.²
   
   u) Administer epinephrine 1:1,000.
   
   0.01 mg/kg IM
   
   Maximum single dose 0.5 mg
   
   **Less than 5 years of age: 0.15 mg IM in the lateral thigh via epinephrine auto-injector or manual administration 0.15 mg in 0.5 mL IM**
   
   **5 years and greater: administer 0.3 mg IM in the lateral thigh via epinephrine auto-injector or manual administration 0.5 mg in 0.5 mL IM**
   
   May repeat every 5 minutes for a total of 3 doses for severe reactions.

¹ (MC) denotes that a medical consultation symbol appears in the protocol at this point.

² JUSTIFICATION NOTE: Due to reduced cost, increased availability, and frequently used dilution solution, D5W has been added as an alternative dilution solution.
PP. Respiratory Distress: ASTHMA/COPD (p. 140 Full Version, p. 85 Pocket Protocol): The following ALERT was added between letters v and w.

MAGNESIUM ADMINISTRATION OFTEN CAUSES HYPOTENSION IN CHILDREN. CONSIDER ADMINISTERING BOLUS 20 ML/KG OF LACTATED RINGER’S WITH THE ADMINISTRATION OF MAGNESIUM.

6. Epinephrine Auto-Injector (BLS) (p. 192 Full Version, p. 115 Pocket Protocol): Changes were made to the dosage regime (letter “f.”)

(1) Patients 3 years of age or greater:
   Adult Auto-injector: 0.3 mg IM

(2) Patients less than 3 years of age:
   Pediatric Auto-injector: 0.15 mg IM

(1) Less than 5 years of age: 0.15 mg IM in the lateral thigh via epinephrine auto-injector or manual administration 0.15 mg in 0.15 mL IM
(2) 5 years and greater: administer 0.3 mg IM in the lateral thigh via epinephrine auto-injector or manual administration 0.5 mg in 0.5 mL IM


(1) Patients 28 months days or greater up to the 18th birthday - if blood glucose is less than 70 mg/dL, administer 2–4mL/kg of 25% dextrose IV/IO to a maximum of 25 grams.
   D25W is prepared by mixing one part of D50W with an equal volume of LR.


(3) Allergic Reaction/Anaphylaxis/Asthma
   (a) FOR ANAPHYLAXIS (ADULT ONLY)
      For patients who are in extremis with severe hypotension or impending respiratory failure, consider initiating an epinephrine drip after having administered 3 doses of IM epinephrine.
      i) Mix 1 mg of epinephrine (either 1:1,000 or 1:10,000) in a 1 liter bag of LR IV/IO. Initiate an infusion with a wide open macro drip titrating to a systolic pressure of greater than 90 mmHg. When drip administered, this will be reported as an exceptional call.
   (b) Adult Epinephrine: 1:1,000
      0.01 mg/kg IM;
      maximum single dose: 0.5 mg
   (c) Pediatric epinephrine: 1:1,000
      0.01 mg/kg IM;
      maximum single dose: 0.5 mg
(d)
(i) Less than 5 years of age: 0.15 mg IM in the lateral thigh via epinephrine auto-injector Epipen Jr or manual administration 0.15 mg in 0.15 mL IM
(ii) 5 years and greater: administer 0.3 mg IM in the lateral thigh via epinephrine auto-injector Epipen or manual administration 0.5 mg in 0.5 mL IM

  d) Contraindications
    (1) Children under 6-5 years of age
    (2) Parkinson's disease
    (3) CNS depression
    (4) Acute CNS injury

• 22. Magnesium Sulfate (p. 231-232 Full Version, p. 120 Pocket Protocol): Multiple changes were made; see below.
  g) Dosage
    (1) Adult:
      (a) Seizure activity associated with pregnancy: 4 grams IV/IO over 10 minutes (mixed in 50-100 mL of LR or D5W)
      (b) Refractory VT/VF: 1-2 grams IV/IO over 2 minutes
      (c) Moderate to severe asthma/bronchospasm exacerbation: 1-2 grams IV/IO over 10-20 minutes (mixed in 50-100 mL of LR or D5W)
      (d) Torsades de Pointes: 1-2 grams IV/IO over 2 minutes
    (2) Pediatric (under 18 years old):
      (a) Seizure activity associated with pregnancy: 4 grams IV/IO over 10 minutes (mixed in 50-100 mL of LR or D5W)
      (b) Moderate to severe asthma/bronchospasm exacerbation: consider magnesium over 10-20 minutes

  **ALERT: MAGNESIUM ADMINISTRATION OFTEN CAUSES HYPOTENSION IN CHILDREN. CONSIDER ADMINISTERING BOLUS 20 mL/KG OF LACTATED RINGER'S WITH THE ADMINISTRATION OF MAGNESIUM**
  (c) Torsades de Pointes: 25 mg/kg to a max of 2 grams IV/IO over 2 minutes

• 20. Glucometer Protocol (p. 279 Full Version)
  (2) PEDIATRIC (NEW '16)
  (a) Patient less than 28 days – if blood glucose is less than 40 mg/dL administer 2 mL/kg of 10% dextrose IV/IO.
  D10W is prepared by mixing one part of D50W with four parts LR.
Recheck glucose after first dose. If blood glucose is less than 40 mg/dL, obtain medical consultation to administer second dose of D10W.

(b) Patient greater than 1 month 28 days or greater until the 18th birthday - if blood glucose is less than 70 mg/dL, administer 2–4 mL/kg of 25% dextrose IV/IO. D25W is prepared by mixing one part of D50W with an equal volume of LR to a maximum of 25 grams.

Recheck glucose after first dose. If blood glucose is less than 70 mg/dL, obtain medical consultation to administer second dose of D25W.

(i) If unable to start IV and blood glucose is less than 70 mg/dL, administer 1 mg glucagon IM/IN.

If you have any questions regarding this memo, please contact the Office of the Medical Director at 410-706-0880.
To: Highest Jurisdictional Authority and EMS Program Directors

From: Rae Oliveira
Director, Office of Licensure and Certification

Date: July 6, 2016

Subject: Maryland’s Move to the National Continued Competency Program for National Registry Certification Renewal

The National Registry of Emergency Medical Technicians (NREMT) has introduced the National Continued Competency Program (NCCP), a new recertification model that streamlines the process into three categories of continuing education: National, Local, and Individual. Benefits of the new model are reduced hours and an increase in the amount of distributive education that can be used towards recertification at the Paramedic level for National Registry certification renewal.

Maryland will move to the new NCCP process in July of 2016 for Paramedic level providers. Since the NREMT is in the process of phasing out the I-99 provider level and encourages the transition to Paramedic by the 2018-2019 recertification cycles, the NREMT will not switch over their current I-99 renewal to the NCCP model. Therefore, Maryland CRT/I-99 providers will have the choice of renewing through the NREMT at 72 hours, until the end their transition period; or renew as a Maryland CRT through a State process that will mirror the Paramedic NCCP requirements of 60 hours. Note: Maryland CRT’s that do not renew through the NREMT 72 hour process will be allowing their National Registry certification to lapse. CRT’s must maintain their Maryland license. If a Maryland CRT allows their State license to lapse, they will be required to reinstate their CRT license in order to function at the CRT level. The reinstatement process for Maryland CRT requires retesting the NREMT I-99 cognitive examination.

BLS providers (EMR and EMT) will continue to renew through the current Maryland renewal process. However, BLS providers who choose to obtain or maintain an NREMT certification will fall under the new NCCP model for National Registry, as well. The chart on the next page highlights the Maryland and National Registry requirements after the move to the NCCP model.

Once Maryland makes the switch to the NCCP model with the National Registry, the new hours requirements will be in effect. However, there will be a one-year grace period for EMS Education Programs to switch their ALS refresher programs over to the NCCP model. Therefore, any approved Maryland refresher courses taken by ALS providers during their current recertification cycle will count toward the new NCCP process and the reduced hours requirements.
For Maryland EMS Education Programs moving to the NCCP model for ALS refresher programs in Fall 2016, or sooner, the Maryland/Local education requirements are located at the end of this letter. The National education requirements can be found in the Paramedic Education Guidelines and is located on the NREMT website, along with other NCCP information at: https://www.nremt.org/nremt/EMTServices/nccp_info.asp. Note: All Maryland approved ALS EMS Education Programs MUST utilize the NCCP model education requirements for refresher courses beginning after July 1, 2017.

We ask jurisdictional authorities and programs directors to encourage ALS providers to visit the NREMT website for information on the switch to NCCP.

Please contact the MIEMSS Office of Licensure and Certification at 410-706-3666 or 800-762-7157 for additional clarification.

<table>
<thead>
<tr>
<th>Provider Level</th>
<th>Maryland Requirements</th>
<th>NREMT Requirements</th>
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</table>
| Paramedic *    | **NREMT Required**    | 60 Hours in a 2 year cycle  
30 hours National (10 can be Distributive)  
15 hours Local/State (10 can be Distributive)  
15 hours Individual (15 can be Distributive)  
Skills Verification |
| CRT/I-99 **    | 60 Hours in a 2 year cycle  
30 hours National  
15 hours Local/State  
15 hours Individual  
Skills Verification | 72 Hours in a 2 year cycle  
36 hours National (10 can be Distributive)  
36 hour Additional (18 can be Distributive)  
Skills Verification |
| EMT ***        | 24 Hours in a 3 year cycle  
4 hours Medical  
4 hours Trauma  
4 hours Local  
12 hours Skills | 40 Hours in a 2 year cycle  
20 hours National (7 can be Distributive)  
10 hours National (7 can be Distributive)  
10 hours National (10 can be Distributive)  
Skills Verification |
| EMR ***        | 12 Hours in a 3 year cycle  
2 hours Medical  
2 hours Trauma  
2 hours Local  
6 hours Skills | 16 Hours in a 2 year cycle  
8 hours National (3 can be Distributive)  
4 hours National (3 can be Distributive)  
4 hours National (4 can be Distributive)  
Skills Verification |

* Maryland Paramedics are required to maintain NREMT certification  
** Maryland CRT's have the option of renewal through either the Maryland or NREMT Process  
*** Maryland EMR and EMT providers are not required to maintain NREMT certification.  
However, those that do may use the NREMT process. Maryland EMR and EMT providers that do not choose the NREMT process must recertify through the Maryland process in order to maintain their Maryland certification.
<table>
<thead>
<tr>
<th>Topic Objectives:</th>
<th>Hours</th>
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<tbody>
<tr>
<td>After successful completion of the below topics -</td>
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<table>
<thead>
<tr>
<th>2016 ALS Protocol Update</th>
<th>3</th>
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<tbody>
<tr>
<td>The provider will successfully complete the 2016 ALS Protocol Update with a quiz score of 70% or greater.</td>
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<table>
<thead>
<tr>
<th>Documentation (Transition to eMeds Elite Platform/Update on new ePCR criteria) – or Local Option approved by MIEMSS</th>
<th>2</th>
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<tbody>
<tr>
<td>The provider will recognize the significance of the move to the NEMSIS v3 data collection platform.</td>
<td></td>
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<tr>
<td>The provider will recall the items to be collected for ePCR submission involved in the move to NEMSIS v3.</td>
<td></td>
</tr>
<tr>
<td>The provider will interpret the mandatory data elements to be collected for ePCR submission involved in the move to NEMSIS v3.</td>
<td></td>
</tr>
<tr>
<td>The provider will interpret the mandatory data elements to be collected for ePCR submission that pertain to CARES.</td>
<td></td>
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</tbody>
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<thead>
<tr>
<th>MOLST Form Review</th>
<th>0.5</th>
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<tbody>
<tr>
<td>The provider will recall the information required for a valid MOLST form.</td>
<td></td>
</tr>
<tr>
<td>The provider will differentiate the levels of care and CPR instruction in section one (1) of the MOLST form.</td>
<td></td>
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<tr>
<td>The provider will interpret the care options defined in sections 2-9 of the MOLST form.</td>
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<thead>
<tr>
<th>Medication Review</th>
<th>2</th>
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<tbody>
<tr>
<td>The provider will give example of indication, contraindications, and doses for adenosine.</td>
<td></td>
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<tr>
<td>The provider will give example of indication, contraindications, and doses for calcium chloride.</td>
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<tr>
<td>The provider will give example of indication, contraindications, and doses for haloperidol.</td>
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<tr>
<td>The provider will give example of indication, contraindications, and doses for magnesium sulfate.</td>
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<tr>
<td>The provider will give example of indication, contraindications, and doses for midazolam.</td>
<td></td>
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<tr>
<td>The provider will give example of indication, contraindications, and doses for morphine sulfate.</td>
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<tr>
<td>Emerging Infectious Diseases</td>
<td>2</td>
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<tr>
<td>The provider will recall several emerging infectious diseases.</td>
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<tr>
<td>The provider will identify infectious patients.</td>
<td></td>
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<tr>
<td>The provider will differentiate various personal protection equipment based on the level of exposure and disease presented.</td>
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<tr>
<td>The provider will describe the unique processes for patient transfer.</td>
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<tr>
<td>Potentially Volatile Environments with Life Sustaining Intervention</td>
<td>0.5</td>
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<tr>
<td>The provider will list examples of potentially volatile environments.</td>
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<tr>
<td>The provider will explain the indications of a potentially volatile environment.</td>
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<tr>
<td>The provider will define the level of care to be conducted in the hot zone of a potentially volatile environment.</td>
<td></td>
</tr>
<tr>
<td>The provider will define the level of care to be conducted in the warm zone of a potentially volatile environment.</td>
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<tr>
<td>12- Lead Electrocardiogram</td>
<td>3</td>
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<tr>
<td>The provider will identify normal sinus rhythm and the associated cardiac conduction phases.</td>
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<td>The provider will identify classic and unusual STEMI presentations.</td>
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<td>The provider will identify false STEMI indicators.</td>
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<tr>
<td>The provider will identify Left Bundle Branch Blocks (LBBB).</td>
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<td>The provider will identify rhythms and rhythm disturbances associated with drug interactions and electrolyte imbalances.</td>
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<td>Life Span Development</td>
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</table>
The provider will identify age ranges, physiologic changes, physical characteristics, and psychosocial characteristics associated with the following:

a. Newly Born
b. Neonate
c. Toddler
d. Preschooler
e. School-Age
f. Adolescent
g. Early Adulthood
h. Middle Adulthood
i. Late Adulthood Geriatric

| Total Hours | 15 |
2016 EMS Leadership Symposium

Friday 11 November 2016

0730 - Registration
0800 – Opening Remarks
0830 – Key Note Presentation – Paul Pepe, MD
0945 – Break
1000 – Equity Issues
1100 – Special Event Planning – Matthew Levy, MD
1200 – LUNCH (SPONSORED by JONES and BARTLETT)
1300 – Surviving Our Own Tragedies – Paul Pepe, MD
1400 – Mobile Integrated Health Care – Jonathan Washko
1500 – Break
1515 – TBD

Saturday 12 November 2016

0800 – NAEMT Congressional Update – Melissa Trumbull
0900 – The Budget Game – A Panel Discussion
1015 – Break
1030 – EMS Suicide Prevention – Amy Eisenhauer
1130 – TBA
1200 – Lunch (SPONSORED by Pearson)
1300 – Split Sessions
  Simulation Exercise
  Grant Writing Exercise
1400 - Adjournment