Meeting was called to order at 1300 hours by Linda Dousa. Chair Eric Smothers is out of town teaching and Vice Chair Rick Udell is on a cruise. She thanked Pleasant Valley Community Fire Company for hosting the meeting and providing lunch. Susan Mott welcomed everyone.

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

Chair report: Linda Dousa asked for approval of the minutes from August 20. Motion by Susan Mott, second by Charlie Simpson to approve the minutes with no changes. Motion carried. Eric Smothers passed along that he would like to thank Dr. Alcorta and the EMS Board and others involved for the narcan for EMR protocol change that went into effect October 1. DVD’s for training were available at JAC and is available on the LMS. He is working on a joint meeting with the Training Committee to develop a combined 5 year plan. He will send more information later.

Association Officers: Executive chair Charlie Simpson spoke about the following: President Bilger is at a dedication in McHenry and sends his apologies for not being able to attend. Thanks to everybody for the work that the EMS committee does. There are lots of things happening including preparations for legislative meetings starting in January. This includes several recruitment and retention initiatives that may help us with membership. The next Executive Committee will be held on December 2nd at Kent Island. It will be a one day meeting beginning at 9am. He welcomed Curtis Wiggins who is the EMS training coordinator for Carroll County. He encourages others from around the state to participate in the different committees in MSFA. There will be 2 training events that will be held in December in Ocean City. Both are on the MSFA website; please check for more information. The new directory is out but he doesn’t have any for distribution at this point.

SEMSAC:
Linda Dousa stated the last meeting was September 7. MIEMSS is working on a bulk purchase plan for Narcan. They reviewed the budgets for EMSOF. UM Upper Chesapeake has submitted an application to move Harford to a freestanding facility. The next meeting will be held on November 2; elections for chair will be held at that time.

ALS Sub Committee:
Marianne Warehime thanked everyone for letters of condolences and attending the viewing after Tim’s death. The committee discussed the following at the request of Eric: 1) Advanced EMT which is another certification through NREMT. The ALS Committee felt that this would be a confusing certification level and is not needed at this point. They would like to see better unified state-wide certifications; 2) training for Active assailant should be optional. This training will take a significant effort and be difficult for many jurisdictions; 3) glucometer for BLS - the committee feels this should be a standard practice for all BLS providers; 4) 12 lead is becoming more common for BLS and should be considered standard instead of optional; 5) duodote training should be standard throughout the state. The committee would like to see provider standardized across the state for all levels. Regarding Narcan, there was a question of firefighters having gone through their health department training being able to administer Narcan on a scene. Dr. Alcorta stated this is a jurisdictional decision.

BLS Sub Committee:
Chris St John said they spoke about the items on the Eric’s list. The group spoke about the need for AEMT when we have already have EMT IV. Do we really want to have another level of training? He said that he will investigate TECC training and self-defense for EMS providers in the context of a yet to be defined training venue at the Convention in Ocean City. This should be discussed with the Training Committee and the Convention Committee. He asked Dr. Alcorta about Narcan IM for providers. Dr. Alcorta said it is expensive and also has the risk of needle exposure. IN has lower risk. Chris said that he contacted the manufacturer of one of the IM narcan kits who said they would provide them at no charge. He will send the information to Dr. Alcorta for further investigation. There was a discussion of the kinds of prescription given to overdose patients when they are released from the hospital. Chris spoke about the new state initiative for narcan in schools in Frederick County. Dr. Alcorta said that MIEMSS helped with this training protocol.

Standards:
John Sullivan had no report.

VAIP / Minimum Ambulance Standards:
Charlie Simpson stated the minimum ambulance standard committee has not met in several months. Dr. Alcorta will try to get an update.

MIEMSS:
Dr. Alcorta:
1. The opioid crisis continues, with hundreds to thousands of overdoses that are being saved through the use of narcan.
   - There is concern over a component of provider burn-out or compassion fatigue. Carroll County did a first responder appreciation dinner where OD victims spoke about their improvement in life based on being saved (sometimes multiple times) and treated and have been clear for years. This dinner was a turning point for some EMS providers having heard the effects they have had on patients’ and patients’ family lives. Every narcan overdose reversal is truly a life saved. Please pass this on to your providers.
   - The EMR providers are authorized to administer narcan as of October 1, 2017 after completing the required training which is provided on DVD or MIEMSS LMS. EMR providers need to get the training ASAP.
   - Some Health Departments are working with the fire / EMS service to create “Safe stations” for opioid users to enter the station for help. AA County has a team that will come to the station to help these people with the rehabilitation resources and provide them with the needed help and hopefully get them into treatment quickly.
   - EMS Operational Programs can and should be sharing overdose information with their local health department (not law enforcement).
   - There was a question of long term effects of narcan on the brain (10 years). Dr. Alcorta said that he is not aware of any effects. He also said that there is no such thing as narcan toxicity. This is an individual response to the reversal of the opioid and consequences of opioid withdrawal. He described the history of opioids; the big influx of use of opioids was after the influx of Chinese opioids centuries ago and the use of opioids to treat the injured during the Civil War. Opium was the drug of choice for pain which was unregulated. Once the federal government established opioid regulations, the opioid market changed from open to black market. During the World Wars physicians used opioids heavily for pain management again. Then physicians were accused of not treating pain in the 1970’s. As the opioid dependency rose in the the population, it became evident that physicians were contributing to opioid dependant
behaviors thus they have realized that they created a large population of opioid users. IN the last 5 years, the process of physician prescription and distributing of opioids is now much tighter and physicians are looking at non-narcotic prescriptions when possible. PDMP (Physician drug monitoring program) started in Maryland in 2014. Dr. Alcorta also spoke about other limits on distribution of opioids including performance measures and penalties for breaking rules. Only about 1/3 of opioid users are result of physician prescribed pain treatment, the rest come from street drugs experimentation.

- Crisis hotline cards are available for handout, please use them on every overdose and give them to the patient or “friend” on scene. MIEMSS is working with Cardinal in an effort to procure a discount for naloxone (3%) (not finalized).
- MIEMSS is also trying to develop some form of compensation for non-transport naloxone expenses ($20-$40 per non-transport incident)

2. The search for a new MIEMSS Executive Director still underway. The last 2 applicants didn’t work out. They are working on hiring a professional search firm to identify qualified candidates. This will take a while.

3. The hurricane relief efforts are ongoing. There were 2 doctors and a CISM team in Florida; several paramedics are scheduled to be deployed to the Virgin Islands.

4. Elite migration - QA and Talbot Counties will be piloting the program soon. They hope to get all jurisdictions on line between January and June 2018. There is a challenge with Physio Control and the SDK9 to SDK10 software interface migration. Jurisdictions will have to manually touch all tablets and computers to make the SDK9 uninstall and the SDK10 installation change. During the transition, an EMSOP may have records in both the current NEMSIS 2.2.1 format and the new NEMSIS 3.4 elite which is acceptable as the patient information will be documented for the EMSOP.

5. Both MSFA leadership and MIEMSS have completed their support of the SIPS. Everyone now needs to change the paradigm to the EMT program is a success story and can be passed. This will improve recruitment and retention instead of a barrier. Maryland students are now exceeding national pass rates.

6. There are two research protocol studies being done in Baltimore City on strokes:
   - A stroke neurologist at Sinai Hospital is in direct contract with treating EMS provider on scene and is given a phone number to talk with the family member or person with the patient to reduce time to fibrinolytic therapy thus saving brain.
   - A positive Cincinnati stroke test and a LAMS of 4 or greater is considered a large vessel occlusion stroke. These patients are being taken to a comprehensive stroke center (Hopkins, Bayview, University) with 24/7 endovascular clot extraction services; they are looking at improving outcomes.

7. There is a health information exchange pilot program in Prince Georges County (Medical Director and QA officer) to look at information in CRISP on calls they responded on (Trauma, Stroke, STEMI, and Cardiac Arrest). They can give feedback to EMS providers. Currently eMEDS is not being uploaded to CRISP since they are not compatible. The opportunity upload should be available once we move to Elite as the NEMSIS 3.4 is HL7 compatible. They are looking for funding (about $300,000) to do this. This will also be critical to MIH efforts for patients. There was a question by Paul Sullivan about MIH. Dr. Alcorta said there are 2 states at present that have rewritten their laws to establish community paramedic programs. This has been submitted to MIEMSS legislature report on MIH.

8. Dr. Alcorta spoke about the 8 items from Eric:
   - EMR emergency protocol approved to administer naloxone done.
   - Cyanide antidote education for all providers (expensive medication) can move into protocol roll out;
• Glucometer being mandatory for all providers has not gone to the protocol committee yet but probably will in 2019;
• Mark I Duodote use needs to be a learning management effort – chempack;
• 12 lead, IV prep, etc. This could be a BLS training area to help ALS providers while ALS provider is engaged with other skills. This can be done at the jurisdictional level currently. There is currently a 12 lead acquisition and transmission by EMT’s as optional but has costs associated with it and therefore he doesn’t want to require it. If it’s standard, everyone must have the 12 lead device and aircards for transmission with hospital receiving equipment. He got push back from protocol committee because they felt the cost was too high. He is willing to entertain this change if we will support it;
• Making all paramedics trained in vaccination program. Providers can only vaccinate their own staff and auxiliary unless there’s an emergency declaration. With Governor declared emergency and approval, CRT-I can do vaccinations (historic);
• The King airway will be standard in 2018 to replace the EasyTube. Ped sizes are better now and this will be part of minimum equipment. Dr. Floccare is working on three tool kits; BLS, ALS and a difficult airway toolkit. The addition of an optional airway will be the LMA. King airways will not be available to BLS providers for ‘18. He will work on it for the future;
• BIPAP for BLS – Dr. Alcorta checking if this is reasonable. There was a question if BLS provider can differentiate between CHF and COPD. This was not on the original list for BLS but for ALS. Bilevel (BIPAP) is setting two differing levels and is more expensive. Committee felt this should be for ALS;
• New students completing National Registry training do not have all things aligned with Maryland protocols (PASG is in the curriculum but not in Maryland scope of practice/protocol). There will always be differences as curriculum of often 5-8 years behind the literature and standards of care.

9. Freestanding Emergency Medical Facility transition from Acute Care Hospitals – MIEMSS is working with MSFA, Harford EMS, UM UCH to address UM UCH’s application. They have looked at transport times, priorities, and support letters. They made a presentation to the EMS Board who will provide guidance to MHCC. He feels this project will move forward. UM UCH has already started the process to become a pilot for acute stroke when FEMF opens in 2021 or 22.

10. Three legislative reports being worked on at MIEMSS:
• MIH projects (metrics – impact on EMS, patient outcome and funding);
• alternative care destinations (2 pilot programs underway Montgomery and Baltimore City) priority 3 only;
• AED placement Report- Concern about AED placement in all restaurants (also discussed co-locating narcan, stop the bleed kits all in AED boxes). Dr. Alcorta provided overview report on Pulse Point software to the EMD committee. Pulse point is an application on civilian phones (shows nearest AED and where the arrest is located). Pulse Point would trigger an alert on cardiac arrests, giving a time advantage. There is a question about personal safety for responders (civilians). Dr. Alcorta spoke about the positives of this program (a robust civilian care community). There was a question if Pulse Point is linked to the Maryland AED registry. Dr. Alcorta said yes so long as the AED is registered on the Public Access Defibrillator program. There is a concern over the cost of Pulse Point and they are looking at strategies for county self-assessment for cardiac arrests.

11. ED overcrowding is a huge issue; HSCRC and MIEMSS are submitting a report to the legislature. The main issue is hospital throughput and they are discussing rules to be put in
place with possible reward for performance and penalties for lack of improvement, (lots of discussion).

12. MSP aviation out of state response from a historic perspective was 30 miles. They are aligning guidance with priority with MSP and only if the delay for priority one Alpha or Bravo trauma is greater than 25 minutes will get commercial. There is a need to identify issues and communication with destination hospital from the field providers with MSP. There is also concern about limitations on cross state lines regionalization of hospitals not recognized by Maryland.

13. eLicensure – scope of work built with Image Trend collaboration has been completed to address issues that have come up. These should be resolved over the next few months. MIEMSS has open positions that are affecting this also.

14. There was long discussion on NCCP and putting information in National Registry in the correct category. There is a lot of confusion and the teaching agencies, National Registry and MIEMSS are giving different information to providers with questions. Dr. Alcorta said that MIEMSS has sent out a letter for NCCP equivalent on certificate (any CME taken in Maryland). It is on the instructor to identify the NCCP equivalent from the list of requirements from NR for all CME they offer. The request to use traditional model for 2017 letter was sent out by MIEMSS. Charlie Simpson asked for a tab on MIEMSS to make sure that everyone has access rather than depending on jurisdictional information distribution. There is a website on MIEMSS under EMS Provider, NREMT Renewal Process (right side). Dr. Alcorta said that he had the March document internal both NCCP models documented on website, reality if there is this much confusion (there is a chart on website) question where to you put them in the NR. The area on the MIEMSS website is home/ems-providers. There were questions about how to meet local option on national registry Dr. Alcorta will get in touch with Rae Olivera and send to Linda for distribution.

**MFRI: Nicole Deutsch** did both ALS and BLS reports. Several handouts were available for distribution. She stated the new textbook policy is working well. Remind students that they have online textbook access for up to 1 year from registering for EMT classes. Etextbooks are starting to be phased in; MFRI will be purchasing more tablets for each region. EMS officer certification; there is no NFPA standard (and never has been) so the course is not eligible for ProBoard certification. Maryland will offer certification based on completion of the course. The new learning management system is in place; they are working out the bugs. Interviews for the MFRI director position will be taking place soon; they hope to have a new director in place in November. She also explained the ALS refresher process that began October 1. There was a question and concern about some jurisdictions having problems getting instructors for EMT (initial and refresher) classes. There has been confusion about who needs to take the computer adaptive test (some think lead instructors; others think all instructors). This is causing problems with getting instructors and apparently each jurisdiction is doing things differently. Nicole stated she would take the concern back and get clarification.

**MSP aviation:** no one present.

**RAC Shock Trauma:**

**Diana Clapp** – stated November training will be burns, December will be stop the bleed, February will be a joint effort with EMS for children on drowsy driving. Airway courses application are on line. The new helipad will be open after one final night test on navigational lights; weight limits for the north pad is 27,500 pounds and the south pad is 38,500 pounds; limit up to 3 small aircraft or 2 large. The north pad will be primary with south pad secondary and weight.
Old Business: nothing

New Business: nothing

Good of the committee: host companies are needed for the February 18 and April 15 meetings. Frederick County stated they will host the April meeting, location TBD.

Next meeting will be held on December 17, 2017 at Darlington.

Adjourned at 1515.

Respectfully submitted
Linda Dousa