NASEMSO Medical Directors Council

January 12, 2022, 12:30 – 5:00 PM PST

LaJolla AB, Manchester Grand Hyatt, San Diego

Meeting Record

Attending – Matt Sholl, Chair (ME), Carol Cunningham, Sec (OH), Richard Kamin, Chair-Elect, (CT), George Lindbeck (VA), Immediate Past Chair, Jon Krohmer (NHTSA Office of EMS), Kate Zimmerman (ME), Doug Kupas (PA), Joe Holley (TN), Jason Kegg (IL), Joe Ferrell (BioSpatial®), Curtis Sandy (ID) Kenneth Williams (RI), William Fales (MI), Peter Taillac (UT), Bill Seifarth (NREMT), Azeemuddin Ahmed(IA), Doug Butler (ImageTrend®), Walt Lubbers (KY), Gale Bradley (AZ), Rob Rosenbaum (DE), Eric Ernest (NE), Michael McEvoy (NREMT), Mark Terry (NREMT), Tori Wadman (emergency medicine resident from University of Nebraska Medical Center)

Call to Order, Welcome, Self-Introductions – Dr. Matthew Sholl, Chair

Dr. Sholl welcomed the group and invited all attendees to introduce themselves

Approval of November 1st Meeting Record – Dr. Carol Cunningham, Secretary

Motion to approve; 1st Dr. Kamin, 2nd Dr. Taillac; approved unanimously

News from NHTSA Office of EMS – Dr. Jon Krohmer

Dr. Krohmer will be officially retiring from the NHTSA Office of EMS on January 29, 2022.

The COVID-19 response continues to be the primary focus of the federal government and NHTSA's partners. Six weeks into the pandemic response, the U.S. Department of Health and Human Services (DHHS) established a healthcare resiliency task force in which NHTSA was tasked to represent EMS. The meeting frequency will be ramping up due to the recent surge. There remain concerns for COVID-19 testing resources and materials, and they are urging DHHS and the FDA to increase access to them by EMS personnel. PPE supply chains are currently sufficient.

As he recalled the diagram of the intersection of EMS with public health, public safety, and healthcare cited in the EMS Agenda in 1996, Dr. Krohmer noted that we needed to continue to be an integral for all of these sectors and strongly suggested that emergency management needs to be added to this list of sectors. Dr. Krohmer encouraged the MDC to ensure that EMS has a seat in every state emergency operations center. He advised that the avenues for federal support for state and local EMS are via the DHHS Hospital Preparedness Program (HPP) and the Federal Emergency Management Agency (FEMA). The HPPs and FEMA have been critical resources to the pandemic response and they need to be more engaged with EMS.

Dr. Krohmer encouraged the MDC to engage with their respective legislators to engage with critical parties on Capitol Hill to increase the funding for EMS. He also encouraged the MDC to educate and promote EMS as an essential service to the community analogous to the current status of fire and law enforcement. There are strong EMS advocates within NHTSA, DHHS, and the U.S. Fire Administration. He challenged all members of the MDC to ensure that they have a position within their respective emergency operations agencies.

Laurie Flaherty is retiring from her position as the 9-1-1 program coordinator and a replacement will hopefully be appointed soon. Although it will not be formally announced until January 13, 2022, Gamunu (Gam) Wijetunge will be replacing Dr. Jon Krohmer upon his retirement.

The NASEMSO MDC thanked Dr. Krohmer for his service to our nation and to the MDC. He was extended an open invitation to attend any of our meetings in the future despite his retirement from NHTSA.

Prehospital Pain Management Evidence-Based Guideline Project – George Lindbeck, PI

Dr. Lindbeck thanked Mary Hedges for her assistance with the project, which was funded by NHTSA, as well as Hannah Degn and his excellent expert panel. The project is 97% complete as a video-based webinar aimed at the EMS provider level is pending. The articles with this evidence-based guideline is published on-line and expected to be in Prehospital Emergency Care soon. This is a culmination of approximately one year of work.

Dr. Sholl complimented the guideline workgroup on the non-opioid options for pain management in the face of the national opioid crisis in the prehospital setting. Dr. Lindbeck highlighted the need for multiple options for EMS instead of being limited to one tool in the toolbox to provide pain management to the patients. He also noted the benefit of shared decision-making with patients with regards to the toolbox for pain control. Multiple MDC members discussed how this evidence-based guideline had a positive impact on their respective state and local EMS protocols, e.g., the addition of intravenous acetaminophen and non-steroidal anti-inflammatory drugs.

Drs. Sholl and Lindbeck cited the improvement in the operational GRADE process comparing the creation of the initial evidence-based guidelines to what is done now. They anticipate that this will facilitate the volume and pace at which EBG can be developed. Dr. Kamin also mentioned a similar process during the AHRQ project to examine pain management. This has also allowed NASEMSO to be selected to manage future EBG development opportunities.

Conversation with the NREMT on EMS Workforce Challenges – Bill Seifarth, Executive Director, discussed the NREMT Survey Findings on EMS Workforce Shortages

Bill Seifarth provided a PowerPoint presentation regarding data that the NREMT has collected regarding the EMS workforce in each state for each level of EMS licensure for 2019-2021. There was a graph on the number of exams delivered by week, and the marked decrease initially at the onset of the COVID-19 pandemic. There has been an increase in the number of EMS candidates seeking testing as well as becoming nationally registered during the pandemic in 2021, and this increase has remained constant over the past 7 years. Late May and early July are the busiest testing times. EMT and Paramedic first-time pass rates have remained constant over the past decade with pass rates of 60-80% and 67-72% respectively.

Despite what is reported regarding workforce shortages, the NREMT data reflects an increased number of people taking and passing the national certification courses and has been tracking the employment sites where graduates matriculate. Mr. Seifarth reported that, from August to September, he attended more than 60 meetings in which workforce shortages were discussed. Examples of anecdotal causes for inaccurate data include less than half of licensed EMS providers in Texas complete patient care reports. He noted all of the non-EMS agencies that are hiring. He cited cardiac catheterization labs, emergency departments, and intensive care units where paramedics are hired in capacities that have traditionally been filled by registered nurses only.

Dr. Lindbeck noted that his EMS provider shortage is beginning to mirror that he is having with nurse attrition where he has seen a 75% attrition rate over 12 months. Mr. McEvoy also noted that the interest, training, and testing of the AEMT level lags behind the other levels of licensure significantly despite the fact that

data shows that 92.6% of all runs can be managed by an AEMT. Mark Terry noted that there is still a low pass rate for advanced EMTs. He also noted that the data he has is from the NREMT and may not capture the data from state specific intermediate levels. Dr. Bradley has noted that some people working in the hospital as a tech will enter paramedic to RN bridge programs and only work in the prehospital setting until they become an RN. She also noted a problem with retirement issues where numbers of people leave over the past 5 years paired with the number of them returning making it impossible for her office to keep up with the process. The issue of significantly less AEMT course offering was raised. Dr. Kamin noted that fewer institutions offer education at the AEMT level and scope of practice because the clinical investment is greater than the delta between the EMT and AEMT.

Mr. Seifarth noted a supposition in 2013 that, when the NREMT required graduation from accredited paramedic programs, graduation would plummet. In reality, successful graduation rates have actually increased. Attrition has a greater impact on the number of graduates. While 1700 candidates do not pass the NREMT exam, 3800 students do not complete the course. He felt that improved pre-course screening is important. Surveys have demonstrated that 25% of educational programs report insufficient resources in medical director support, facilities, and finances.

Mr. Seifarth stated that for the paramedic programs there is a 22% attrition with approximately 2,000 who failed to pass the exam. Quality of the education programs varies widely across the county. When schools have a lower number of enrollees and less resources, this correlates with poorer success. Rather than closing these schools, they should be provided support to fill their resource gaps. The turnover rate for paramedics due to departure from the profession is 13,000 to 19,000 annually. The majority of students pass the Registry exam and then leave the profession especially at the paramedic level. Causes for departure from the profession include:

- Higher pay/benefits
- Decision to pursue higher education
- Dissatisfaction with management
- Desire for career change
- Lack of feedback regarding performance or patient outcomes
- Excessive numbers of work hours

Mr. Seifarth noted that a similar longitudinal study is planned to also include fire personnel. The NREMT data does not demonstrate that there are less candidates passing the test and they have not lowered the standard set by the test. As such, certification of new EMS providers is not the cause for the workforce shortage.

Dr. Kupas noted that other agencies are approaching legislators for less challenging or less expensive testing options. Many of his legislators are embracing dangerous avenues to address the problem with workforce. Others have experienced the similar challenges.

On Friday at 4:45 PM, the NREMT will be making a presentation on critical thinking and critical judgment of EMS candidates that are upcoming for their 2023 with the associated advanced in technology.

Dr. Bradley noted the change in the distribution and weighting of on-line and in person training and overall distributive education. Mr. Seifarth noted that the NREMT is actively looking at these options of continued clinical competency. Dr. Ernest noted that in Nebraska, distributive education has increased the access of rural EMS providers to educational content. There was an inquiry about the availability of this data at the zip code level. Dr. Lindbeck noted that this should be down cautiously as this data is sensitive and many regions will interpret it as a punitive measure rather than the foundation of supportive action. Dr. Sholl asked about the factors that may be contributing to varying number of lower test scores with lower students in a class. Mr.

Ferrell inquired if the NREMT data took into account the fact that some EMS providers are not actively practicing versus those who are. Mr. Seifarth stated that they are looking at avenues to support poor performing EMS education programs rather than leaving them no other option other than to close.

Dr. Sandy noted that the role of the EMS medical director was much more active when his state was doing the testing of EMS students versus the standard now where CoAEMSP is overseeing the testing and the medical director simply signs forms. Dr. Kupas noted that the tests that were generated by another organization, the exam questions did not align with the validated exams that are offered by the NREMT. Dr. Sholl closed by noting that knowing the fundamental of assessing how the EMS provider is performing and feedback that EMS medical directors can and should provide. He also noted the community expectation and resource development should include the increase in clinical exposure to EMS providers and sharing of equipment and resources. Communities should be encouraged to examine the certification levels of their EMS resources and design a way to maximize the use of the EMS providers within their scope of practice. Dr. Sandy noted the staff attrition in his own EMS office and many of them have never been inside of ambulance creating a disconnect regarding the knowledge of functioning EMS providers. Dr. Kamin discussed the rural experience in Connecticut and how they resisted working with neighboring communities and sharing resources. Dr. Krohmer provided golden nuggets of knowledge, words of wisdom, and astute advice for the solutions that are created.

Dr. Taillac noted that during his meeting with the NEMSAC the COVID-19 pandemic was conspicuously missing from their work plan. Dr. Cunningham noted that NASEMSO was contracted by the U.S. Fire Administration and federal partners to oversee the pandemic study for operational response. Mel House is the NASEMSO program manager for the project.

2:00 – BREAK

DEA Rulemaking "Protecting Access to Emergency Medications Act" – Dr. Ritu Sahni
Dr. Sahni was unable to attend the meeting

MDC Work Plan 2022-23 - Dr. Matthew Sholl
Dr. Sholl presented the draft work plan as updated at the end of 2021 by the current Executive Committee of the MDC and introduced the new tasks (4-6). Task 4 focused upon a review and update of the role of the state EMS medical directors, as particularly identified during the COVID-19 pandemic, that will be of benefit on a daily basis.

Task 6

Potential new tasks were discussed by Rich Kamin and Matt Sholl. Rich highlighted the utility of the MDC listserv, and he has approached NASEMSO about supporting an on-line platform to better facilitate communication with other agencies and to collate the responses for inquiries presented. A discussion regarding the benefits and hurdles that exist and need to be overcome when approaching NASEMSO for a request.
Dr. Sholl invited MDC members to send him any additional ideas for new tasks to be added to the work plan.
Peter Taillac suggested that we ask NASEMSO for their input on what tasks they would like the MDC to address.
There was a motion 1st Ken Williams and 2nd Rich Kamin. All approved the MDC draft work plan.

New ACS Field Triage Guidelines – Dr. Douglas Kupas
He provided a history of the Field Triage Guidelines that originated in 1994. He stated that 14 organizations have endorsed the latest version of the document thus far. He noted the difference in the new ACS Field Triage Guidelines. It uses likelihood ratios rather than statistically associated criteria. He predicts that there may present a challenge on how it is presented to EMS providers and their decision-making processes. He used a ground-level geriatric fall on anticoagulation where EMS providers may feel that all these patients, even if

neurologically intact, need to be transported to a trauma center rather than a healthcare facility that has CT scan capability. The new protocol includes clinician judgment which create angst depending on the education and level of certification of the EMS provider as well as the variances in resources within a healthcare system. He cautioned that many states may take the bullet points and implement them as mandates without any flexibility that can be instilled by the EMS provider or the EMS medical director. The draft document was previously circulated to the MDC. Dr. Krohmer informed the MDC that the draft is currently in final editing review. A discussion ensued regarding utilization of available resources within these scenarios.

State Reports - Members to give brief (2-3 minutes) updates, focusing on current, state specific issues

Rhode Island: Ken Williams reported that his EMS office staffing has increased adding a data quality staff member and an epidemiologist. They have experienced a decrease in opioid overdose deaths and is working with hospitals for diversion cases. They have been using NEDOC scores. Standards and practice measures in legislative process, and has some EMS systems administer monoclonal antibiotics.

Utah: Peter Taillac reported that designation of EMS as an essential service passed as state law and, as a result, every city is required to fund EMS. Legislation to support the stroke task force was also passed. All hospitals are required to participate and report their data to the stroke registry, which includes CARES. The state is providing $75,000 annually to support their time-critical diagnosis initiative. In lieu of 911 diversions due to COVID-19, medical response teams comprised of high-level physicians and system leaderships have been established to identify beds in the state and allow distribution of patients via interfacility transfers.

Virginia: George Lindbeck – No report was given

Iowa: Azeemuddin Ahmed: As an intermediary for a state initiative, measures are being taken with county boards and supervisors to recognize EMS as an essential service that will allow local jurisdictions to vote to have a tax levy to fund EMS. They are also creating an 11-member physician board of advisors to support him although he has not been granted a vote. Iowa is challenged by a 65% volunteer workforce, strained and overworked rural providers, and minimal resources to support mental health and resiliency.

Kentucky: Walt Lubbers: CARES program was started statewide and is funded so far. Scopes of practice are being developed for advanced practice paramedics (community paramedicine, critical care, air medical, wilderness, and tactical) and there are plans to begin EMS specialty care certifications and testing. Local EMS systems are in the process of creating regional protocols. Challenges include hospitals citing lack of interfacility transfers especially when beds are lacking, significant EMS workforce turn over, and a proposal to revisit the creation of an EMT-Cardiac and EMT-IV.

Arizona: Gail Bradley: They have looked at the various settings where EMS can function (inside and outside of hospitals) and established state requirements for medical direction and scope of practice. They have drug tables for interfacility and healthcare facilities both of which require medical direction. They have a new bureau chief who has created a closer relationship between EMS and emergency management. There have been issues a voluntary cardiac system of care for out-of-hospital cardiac arrest and STEMI centers that have minimal requirements for 24-hour cardiac cath labs and associated metrics. They are also challenged by lack of staffing and their impact on trauma center designations and recertifications.

Idaho: Curtis Sandy: They have been on crisis standards of care for EMS for 4 months. He gave an overview of hot spots from COVID-19 and utilized the alert sense system of unloading patients. They have adopted cardiac arrest under their time-critical diagnosis centers. Eighty percent of their hospitals are designated as trauma, stroke, and/or STEMI centers with the majority of trauma centers as a level 4. Their registries are beginning to

submit good data. He noted that 68% of EMS providers are volunteers. There is $2 million of funding available, but they have not decided upon which it spent.

Illinois: Jason Kegg: They have had multiple changes in their EMS leadership teams, but the state addressed the COVID-pandemic well. They just ended crisis standards of care. There have been recent debates on ambulance staffing and diversion as well as hospital bypass. More EMS systems exploring tiered response. As more smaller emergency departments are having difficulties transferring patients to other facilities, they are exploring options, including a statewide one-call system; however, funding remains a hurdle. Mental health and COVID-19 related issues are now challenging their resources and transfer destinations. Recently passed emergency rules to address hospital bypass and diversion. Nursing shortages have caused them to consider paramedics filling segments of their roles.

Dr. Krohmer mentioned a document from ASPR Tracie that is a resource for various models of hospital diversion and/or bypass

Delaware: Robert Rosenbaum: They recently have entered crisis standards of care and he initiated a moratorium on hospital diversion during peak hours for the past two weeks. EMS units from other states do not currently have the information regarding Delaware's diversion status and avenues to communicate this information to them is in process. Delaware will accept critical patients. They are looking at hosting an EMS fellowship with the application awaiting approval. Two pilot projects involve whole blood administration and point-of-care ultrasound for cardiac arrests

Nebraska: Eric Ernest: They received a CDC health disparities grant that is being used to provide telemedicine in rural areas. Mobile integrated healthcare issues include licensure difficulties. They are working on implementing an ultrasound education program for EMS. A funded state data registry has been approved. EMS providers are able to treat police canines and they are reviewing the educational standards for advanced EMTs.

Matt Sholl noted that Kate Zimmerman has developed statewide protocols for the treatment of canines after they supported the legislation to make it happen. Kate is willing to share Maine's protocol for veterinary care with the MDC.

Tennessee: Joe Holley: He noted the political effect of COVID-19 that has slowed down and altered the regulatory process. Based upon ambulance wait times, they developed a green-yellow-red system where EMS do not park and wait for a bed when the system hits red. They have instituted a policy where EMS can carry and leave a patient on an extra cot or a lawn chair to shorten off-load times and make EMS available to respond to other 9-1-1 calls. They developed a state guideline that the majority of agencies have adopted as their own protocols.

Michigan: Bill Fales: New division director was appointed with experience in EMS and trauma. There was a statewide monoclonal antibody administration initiative. Workforce shortage is challenging with some systems forced to transition to a two-tiered system. They were able to increase EMS agency reimbursement from state Medicare and Medicaid for monoclonal antibody administration, and many agencies were able to increase employee payment, purchase equipment, and provide training.

Pennsylvania: Doug Kupas: The state protocols were updated with some emergency COVID-related measures. They used Indiana's data to support antibiotics administration for open fractures, often within 30 minutes, and the results were beneficial. Ground services are administering cefazolin, but air services use antibiotics with broader spectrum. The EMS director has recently resigned and a search for a replacement is ongoing. The legislators wanted a list of statewide primary stroke centers that did not include comprehensive stroke centers.

There are neurosurgeons that are supporting a device company to identify large vessel occlusions (LVOs) and legislation to mandate a specific protocol to identify LVOs.

Dr. Krohmer noted that this group made to presentation to the National EMS Advisory Council. They advised the group that individual states control over their specific legislative language and citations.

Dr. Kupas stated that a task force was created within their state to explore the data regarding the performance of rapid sequence intubation in the field. He mentioned the national initiative to create 9-8-8 for mental health crisis/emergencies is being discussed in the legislatures and advised others to look out for similar legislative initiatives. He also mentioned a discussion with the Assistant Secretary of Health regarding reimbursement of cardiac arrest even if there is field termination in exchange for CARES data and payment for performance. Further discussion on this topic has stalled due to the COVID-19 pandemic.

Dr. Krohmer provided an update of 9-8-8 for mental health and it is a result of federal legislation. There will be an upcoming EMS webinar to discuss the project. He requested that each state 9-1-1 staff and centers become connected with those that are involved in the 9-8-8 participants to address the potential "disconnect". The plan also is anti-law enforcement and is effective on June 17, 2022.

Due to a contractual agreement with the conference hotel, the Medical Director Council had to exit and clear the conference room by 5 PM. Due to lack of time, the MDC was unable to receive state reports from Maine, Connecticut, and Ohio or the scheduled project and committee reports.

The meeting was adjourned at 5 PM.

The meeting minutes were submitted by MDC Secretary Dr. Carol Cunningham.