**FLORIDA EMERGENCY MEDICAL SERVICES (EMS) ADVISORY COUNCIL**

**Meeting minutes** from the meeting of:

November 17, 2015

Orlando Marriott Lake Mary

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| **Member Name:** | **Voting Status:** | **Attendance:** |
| Steve McCoy, EMS Section Administrator | Non-Voting | Present |
| Charles E. Moreland, Ed.D., Chair | Voting | Present |
| Daniel Griffin, EMS Educator, Vice Chair | Voting | Not Present |
| Chief Darrel Donatto, EMS Administrator (Fire) | Voting | Present |
| Michael Lozano, M.D., Physician | Voting | Present |
| Doris Ballard-Ferguson, Ph.D., Lay Elderly | Voting | Not Present |
| Jane Bedford, Paramedic (Non-Fire) | Voting | Present |
| Sheila Bradt, Emergency Nurse | Voting | Not present |
| Alan Skavroneck, Commercial Ambulance Operator | Voting | Present |
| Isabel Rodriguez, EMT (Non-Fire) | Voting | Present |
| Danita Allen, Hospital Administrator | Voting | Present |
| Orly Stolts, EMT (Fire) | Voting | Not present |
| Bari Conte, Air Ambulance Operator | Voting | Present |
| Angela Alban, Lay Person | Voting | Present |
| Mac Kemp, EMS Administrator (Non-Fire) | Voting | Present |
| Tracy Yacobellis, Department of Education | Non-Voting | Present |
| Charles Hagan, III, Office of the Governor, Emergency Management | Non-Voting | Not present |
| Captain Timothy Roufa, Department of Highway Safety & Motor Vehicles | Non-Voting | Not Present |
| Preston Bowlin, Department of Financial Services | Non-Voting | Present |
| Trenda McPherson, Department of Transportation | Non-Voting | Not present |
| Carlton Wells, Department of Management Services | Non-Voting | Not Present |
| Joe Nelson, D.O., State EMS Medical Director | Non-Voting | Present |
| Julie Bacon, EMSC Liaison | Non-Voting | Not Present |
| Bethany Lowe, Meeting Coordinator | Non-Voting | Present |

Note: A verbatim transcript of the entire meeting is available for review at the Bureau of Emergency Medical Oversight, EMS Section.

**Call to Order:**

Chair Moreland called the meeting to order at 1:00 p.m. The Pledge of Allegiance was recited.

A roll call was conducted and a total of ten voting members were present; therefore, a quorum was met.

**EMS Section Report:**

The newly appointed Interim EMS Section Administrator, Steve McCoy, extended his thanks and congratulations to John Bixler, the previous EMS Section Administrator, who had announced his retirement from the Department of Health (DOH) last month. Mr. McCoy announced that the position will be vacant for 30 days.

He extended thanks to the Trauma System Administrator within the Bureau of Emergency Medical Oversight, as she had recently announced her resignation. Her last day will be on November 30, 2015. Mr. McCoy also extended thanks to Cindy Dick for returning to the Division of Emergency Preparedness and Community Support as interim director due to untimely medical issues with the previous interim director, Mike McHargue.

Mr. McCoy then asked that each council member review their operations and come up with better ways that can produce a good outcome for patients instead of just sticking to the way things have always been done. He encouraged members to be more aggressive with their decision-making either in helping the EMS office with their own decisions or actually provide recommendations from the council itself.

Mr. McCoy has observed the units within the EMS Section office, such as the grants, planning and licensure units. He has directed each unit to interact and work more together as a team to allow the state to meet certain requirements.

Next, Mr. McCoy announced recent updates within the EMS office. The EMS Section’s webpage has been updated into a more user-friendly format. Also, a BEMOcomm newsletter has been created to announce achievements and special events from across the state. Please notify Bethany Lowe if you have any ideas to be included in BEMOcomm. A webinar series was created to provide state training to the public. This webinar will give our stakeholders an inside look of the state office’s processes such as grant applications, licensure renewal and EMS for Children program planning.

Mr. McCoy then reported on the upcoming rule development packages. Their first one is the reduction package that was released about a year ago. The changes had already been debated and they would soon release information regarding the final outcome of the package. The second is the rule workshop to adopt the trauma triage criteria from the Centers for Disease Control and Prevention (CDC). This workshop is planned to take place in December or after the holidays. Mr. McCoy then mentioned that estimated regulatory cost changes would be coming to the recent versions of the General Services Administration (GSA) standards for ambulance design and construction.

Mr. McCoy reminded everyone that the deadline for submitting matching grant applications is March 9, 2016. He encouraged agencies to submit their applications in a timely manner to ensure each one is reviewed and fully considered.

Chair Moreland then echoed Mr. McCoy’s comments regarding a consistent message toward the council, the constituency groups and members of the EMS community. He encouraged members to stay in contact with one another to lessen any gaps in communication.

A motion was received to approve the minutes for July and August.

**Medical Director’s Report:**

Dr. Nelson reported that the Florida Association of EMS Medical Directors recently met and the General Motors Corporation OnStar Program presented on the advanced automatic collision notification system. A few communication centers in the state were beginning to use that data, which helped predicting the types and severity of injuries.

Dr. Nelson then announced an ongoing project called EMS Compass, which has been distributed by the National Association of State EMS Officials (NASEMSO) and funded by the National Highway Traffic Safety Administration. The sole purpose of this project is to create EMS performance measures. NASEMSO created a committee to carry out those performance measures. The first measures were developed around stroke and are available at: [www.emscompass.org](http://www.emscompass.org). Dr. Nelson provided details on another national performance measure that allows agencies to compare themselves to other similar agencies.

Dr. Nelson expressed interest in discussing the REPLICA CompAct with Dia Gainor, NASEMSO’s Executive Director, at the next EMS Advisory Council meetings. He is still awaiting for the confirmation of her availability.

Dr. Nelson discussed automatic epinephrine injectors (Auvi-Q). There had been a recall made on that specific brand name due to the injectors under-dosing the patients. Some EMS agencies still may have been using that injector but paramedics should understand that some have been recalled. Possibly the entire production had been recalled. If your agency receives an allergic reaction call and those injectors are being used, be aware that the first dosage will most likely not help the patient due to the malfunction of the product.

Dr. Nelson then stated that the medical directors are looking into the CARES Registry in hopes that Florida will participate statewide. The medical directors were familiar of the CARES Registry for the most part and a few agencies in Florida had participated for a few years.

The American Heart Association recently updated their Advanced Cardiac Life Support Guidelines. EMS agencies are starting to adopt those guidelines into their protocols. To improve stroke care, efforts made on national and regional levels needed to be looked at and supported. Agencies within the state are having trouble with transporting to primary versus comprehensive stroke centers. They are determining destination protocols.

Dr. Nelson then stated that the model stroke determination form is being revised and a final draft is to be provided in January. Mr. McCoy stated that he would like for the council to recommend that the EMS office adopt the final stroke tool.

Dr. Moreland stated that the EMS State Plan will be developed into a smaller version of the council’s Strategic Visions Plan. Cory Richter and council members will tweak the EMS State Plan for eventual approval. There will be information about the different committees available soon on the website for new members review.

Dr. Moreland then welcomed two new council members:

* Angela Alban, Lay Person: Ms. Alban is the CEO of SIMETRI in Winter Park. Her work is based in medical training and education.
* Mac Kemp, EMS Administrator (Non Fire): Mr. Kemp is the Deputy Chief of Clinical Affairs at Leon County EMS in Tallahassee.

Dr. Moreland then made updates on the council’s sub-committee assignments:

* The new chair of the Data Committee is Chief Donatto.
* There will be co-chairs to each committees with the exception of EMS for Children.

As a member of the council please learn the sub-committee assignment. There will be times when members are not present and you would have to step in to fill the spot.

Leah Colston, Chief of the Bureau of Emergency Medical Oversight, stated that the concept of regional trauma agencies was born from statutory requirements to build regional trauma agencies in each of the seven Regional Domestic Security Task Force (RDSTF) regions. The DOH has started this process with the development of two pilot regional trauma agencies. These pilots could better determine what the community needed because the DOH was not the most qualified to do so. Volunteers from two regions, Region 2 (surrounding areas of Leon County) and Region 5 (central Florida) got involved. Since both areas are different demographically and population-wise, it’s a good structure that could be used statewide.

Dr. Peter Pappas with the Executive Committee of the Florida Committee on Trauma, provided an update on the trauma agency pilot. He mentioned an impeding change to 64J-2, their part of the administration code (forming trauma agencies in line with the regional domestic security task force regions). The statute dated back to 2004 and was a part of the state’s response to the events of 9/11. Supporting sections 395.401, 404 and 4045, Florida Statutes, which deal with what these agencies will be about.

Trauma service plans and the trauma registry (including EMSTARS, EMS providers and transport protocols) is their biggest revolution/evolution of state trauma system since the establishment of Level I, Level II designations and the establishment trauma protocols from the late 80’s and early 90’s. The goal was to create administrative units for the trauma centers across the state based on the RDSTF’s. It is a rough model of the RDSTF and it is larger than some countries in Europe. It extends over nine counties (from the Volusia/Flagler line down to the Martin/Palm Beach line). The mission of the agency was to establish a trauma agency in accordance with state of Florida rules/regulations and the American College of Surgeons’ Committee on Trauma Survey. The mission was currently in draft form. David Freeman, co-chair of the Central Florida Disaster Medical Committee, is also trying to get the mission on board.

Dr. Pappas stated that the American College of Surgeons devised this plan to take the concept of the trauma agency as developed but move it to a more regional level. Good communication was not established back then because they would often forget to tell the EMS medical directors what was needed in Florida to make the system more organized. The DOH then adopted the idea of turning a general trauma agency concept into a regional level; they picked up the concept of aligning them with the RDSTF’s. Communication is key and the main focus is always the patients.

Dr. Pappas stated there must be a joint trauma and EMS leadership of these agencies (Level I and Level II centers as well as non-transporting agencies). Everybody had a part to play and it was vital for everyone to speak up on their own work and how things should be flowing. The basic outline of the draft was to think of the agency as stakeholder sections; the sections would appoint individuals to an executive committee. This executive committee would appoint individuals to stand in as ad hoc committees. The stakeholders consisted of the trauma centers, EMS agencies, acute care hospitals, those defined as not holding trauma centers, county health departments and extended care rehabilitative care centers. In the regions where they existed (certainly trauma agencies; existing before July 1, 2004) would have a seat at the table and will be a member of the executive committee. Sovereign tribal nations would also be included.

In the model, there are co-chairs, trauma center chairs and transporting EMS agency chairs. There are two co-vice chairs representing either a trauma center or an EMS vice chair. The idea was to keep both executive privilege and executive responsibility with the two critical halves of the trauma system (EMS and trauma centers).

For the Region 5 executive committee, they would like a trauma and EMS co-chair; two additional representatives for trauma and EMS representing Level I and Level II, as well as transporting and non-transporting centers who alternate as vice chairs. Also on the committee would be an acute care representative, extended care representative, country health department representative, as well as the municipal and country governments.

Dr. Pappas stated that the municipal aspect was very important for the trauma centers because they needed representatives for their cities where they are headquartered. Hearing the voices of both the municipal and country governments is important because things tended to be different.

He stated that Regions 1, 2 and 4 all had significant assets. He felt it was important to have a Department of Defense representative because tens of thousands of deployed personnel depend on their services. Since a vast majority of the specialists in the trauma centers are private physicians whose representation is through medical societies, it was very important to them to have them as a representative as well.

Another opportunity for official representation is from the EMS Advisory Council. The committee structure was divided into three groups. Dr. Pappas took a look at what are called “core mission committees,” which involved items that were within Florida Statutes, and are of practical necessity followed by supporting mission committees. Both the joint trauma and EMS best practices should be on the same approach to taking care of their patients.

The ability to have a joint committee and to look where the needs are within the entire nine county region for Region 5 is vital. A joint Trauma and EMS Registry Committee can serve as a bridge between Tallahassee and federal requirements for registry and other organizations such as NEMIS for EMSTARS and the American College of Surgeons for TQIP. Essentially the committees could serve as an aid and support individual centers as agencies.

A special population subcommittee would have its own two sections. The focus would be on burns and pediatrics, as well as brain and spinal cord injured patients. They needed to have their place and opportunity to discuss issues that were unique to those populations. Supporting mission committees would come online within about a one to two year timeframe. The online work would cover joint trauma, EMS training and education, injury prevention outreach, disaster management and also at-risk patient care.

Dr. Pappas stated that many of the trauma centers had issues with finding inadequate rehabilitation centers for patients with limited funding. The ad hoc committee that is really needed is the Trauma Center Application Review Committee. The biggest issues that had affected the trauma system was how it grows and where. RDSTF trauma agencies were per written statute as agencies must have a say in terms of how the centers are structured, where they would be and what would be done with applications.

The “nuts and bolts” are the quarterly meetings as a cost-saving measure. He suggested that the meetings be held either at the Region 5 trauma centers and EMS agency headquarters. There was no constitution for their committees, no set of bylaws coming from Tallahassee and Washington. If they wanted to change a rule, it would take a three-fifths vote within the current structure.

On the executive committee, cooperation and coordination across disciplines and stakeholders are important. If at any time an individual feels that their stakeholders are not doing what needs to be done, they may be impeached and removed. The idea was the Executive Committee members are responsible for stakeholder constituents and where people think outside the box.

In terms of funding mechanisms, Dr. Pappas stated that the Central Florida Disaster Medical Coalition in and of itself would be able to offer seed money. Health and human services grants are available, as well as funding from the ASPR. He mentioned that he had thought of other funding sources as well, such as a charitable foundation and potential for membership fees. He would like to generate the money locally, so that they could have a little more control over things.

Dr. Moreland then recommended Dr. Nelson to represent the EMS Advisory Council on the executive committee because his presence is very vital for the process.

**Council Member Reports:**

Tracy Yacobellis, Department of Education (DOE):

Ms. Yacobellis stated that the Florida Association of EMS Educators (FAEMSE) met the previous day. Topics of discussion included a recent call that went out to all EMS educators wishing to serve as National Registry of Emergency Medical Technicians (NREMT) representative. The EMS office would select interested candidates based upon geographical needs across the state. The DOH’s Division of Medical Quality Assurance has developed a new form for program directors to sign attestation that students completed the program and had a valid CPR/ACLS card.

The NREMT’s paramedic exam is going through a change. They are preparing to transition to the NREMT assessment exam coming up this January. The NREMT scenario validation workshop recently took place and was facilitated by David Page and sponsored by Fisdap. The FAEMSE has requested additional workshops for program directors who were unable to attend last month. The workshop was important for program directors in preparation for 2017 NREMT paramedic psychomotor assessment exam. The review process for EMS curriculum frameworks had concluded and resulted in updates for both EMT and paramedic programs. The EMT program was expanded to 300 clock hours (12 credit hours) starting in the 2016-17 school year. Additional instructional time is needed in the EMT program (supported by the Bureau of Emergency Medical Oversight) pursuant to the requirements of section 407.27, Florida Statutes. The change in length would affect all programs that contained the EMT training program. Clock hour programs, credit hour certificates and fire fighter/EMT combined programs were all created that current school year. Within the EMT and paramedic programs, the Health Core Foundation’s course and objectives were eliminated. For EMT, the Health Core’s objectives were put into the EMT curriculum to ensure students would receive credit even if they decided to move to another health science program. It was not necessary for students to have it in paramedic curriculum so it was completely removed.

The EMS and paramedic curriculum frameworks were also updated to encompass the national EMS standards. These frameworks were posted in draft on the DOE’s website in January. It will proceed to the State Board of Education for approval usually between February and April. Once approved, they would be available for use starting in the fall of 2016.

Darrel Donatto, Florida Fire Chiefs Association (FFCA):

Chief Donatto stated that the FFCA were closely monitoring ACHA’s efforts to revise their guidance on Medicaid reimbursement. It is a great concern and they are highly involved in the process through their lobbyists. The FFCA also worked on legislative relief for EMS providers due to the fiscal impact of change orders in the vehicle design standards. They adopted a legislative position paper that is available on their website. It lets you see where they stand on issues related to the fire service (EMS included).

Chief Donatto stated the FFCA believes a focus on being prepared should be a very high priority, due to attacks in Europe and threats made directly to the U.S.

The FFCA has recently hired a new executive director, Therese Sheey. She will be at the upcoming council meetings in January, so everyone will be able to meet her there. The EMSAC meetings are held in conjunction with Fire Rescue East, this provides a lot of educational opportunities and interaction with vendors, as well as a few competition events.

Florida Council of EMS Chiefs (FCEMSC)

Mac Kemp reported that the focus of the EMS Chiefs meeting was the integration and cooperation within our communities on various issues. They are currently doing that with STEMI, stroke and trauma. Community paramedic is very essential, they had to do it in conjunction with dozens and dozens of partners in their community. Performance-based pay is demanding this from them and the industry must change. The attacks in Paris is pushing everything faster.

The attacks are called a complex coordinated attack. It’s different from active shooting; active shooting is just one person shooting at a crowd because they are mad at somebody or something. Complex attack are done by terrorists who are in multiple locations at the same time. They are done with careful planning and designed to kill as many as possible. They kill the first responders and disrupt and overwhelm the local resources.

Chief Kemp stated that there are many courses that under way on this topic. He is currently working on with Louisiana State University (LSU) with the National Center for Biological/Biomedical Research and Training (NCBRT). They were doing a complex coordinated attack course that would be launched in the spring.

Pilot one was recently completed in Chicago. Pilot two would be in Alameda, California. Chief Kemp is working on the third pilot to take place in Florida. The course will be offered by LSU through the NCBRT. The idea behind the course is for law enforcement, fire, EMS and other community partners to unite in finding a way to respond to those types of attacks. EMS agencies realize they must pair up with the law enforcement agencies to respond so they can begin taking severely injured patients out and saving their lives.

Chief Kemp stated that the model is well thought out. The Department of Homeland Security and Federal Emergency Management Agency (FEMA) have provided their input and approval. The course will be offered nationwide. All Florida agencies need to take this into consideration and prepare because it cannot be done alone. It involves community effort.

Chief Donatto stated that last year, there were legislation filed on school safety, Senate Bill 72. Schools would coordinate with law enforcement on active shooter plans but there was no mention of EMS. The FFCA had taken official position to oppose the bill without some modification. They will pursue something that says those plans must be coordinated with EMS providers and law enforcement. Nobody works alone, we all work together.

**Committee Reports**

Medical Care Committee:

Dr. Nelson stated that the National Association of Athletic Trainers (NATA) were making recommendations to athletic trainers when handling spinal cord inured athletes at events. NATA represents about 60,000 trainers ranging from high school to professional sports venues. The recommendations given to the athletic trainers would impact EMS when their services were provided at athletic events.

Their first recommendation was to increase cooperation and pre-planning between athletic training staff and local EMS agencies. They wanted to establish a strong communication between the athletic team staff and their local EMS medical director to ensure an effective plan was set into place when an athlete was seriously injured. Their second recommendation was to remove protective equipment as soon as possible when the player is either on the scene or off to the side of the field before they were transported. The removal of equipment should be handled by the person who knows the equipment intimately because the technique of removing the equipment will vary from not only sport to sport but manufactures of equipment within the same sport. Their third recommendation was to place the athlete onto a rigid immobilization device (spine board, scoop stretcher). The question that came into play was “What do you do with that patient if your EMS protocols have done away with the use of spine boards?” There was dialog between NATA, American College of Emergency Physicians, National Association of EMS Physicians, National Association of State EMS officials and others to find the right language for that recommendation.

The third recommendation led to the discussion of spinal boards. Some EMS medical directors had completely done away with them. Some trauma surgeons recognized that some patients needed to be removed from the spinal boards because of potential harm but at the same time, the boards could be of value for those who are severely injured. There was a range of opinions from no spine board use, spine board use on all patients and spine board use on some patients. It had been concluded that much more research needs to be conducted. It was suggested that EMS agencies get with their local trauma specialists and discuss these issues to reach a resolution. It will most likely be a topic of discussion over the next several years in EMS.

PIER Committee:

Cory Richter stated that the PIER sub-committee is working on a huge project with EMS for Children, the Florida Department of Transportation and the Pedestrian Bicycle Safety Coalition. The details of this program would be similar to the motorcycle program that was done a few years back during EMS week. It is based on pedestrian bike injuries, most common injuries and treatment modalities. The program will be presented in May 2016, during EMS week. The outline has been started and would soon be on the way.

Legislative Committee:

Alan Skavroneck stated that the following legislative items were discussed in preparation for the upcoming season:

* House Bill 221 for health insurance coverage for emergency services is a similar bill that was introduced last session that prohibited EMS providers from balance billing patients.
* House Bill 391/Senate Bill 320 created an exemption from public record requirements for certain identifying and location information of current or former EMTs or paramedics, including their spouses and children.
* House Bill 345/Senate Bill 456 for firefighters and paramedics: this bill provides a death or disability due to cancer suffered by firefighter or paramedic employed by the state or political subdivisions, is presumed accidental and suffered in the line of duty under certain conditions.
* House Bill 517/Senate Bill 742 for licensure of support services: required county governing bodies to adopt ordinances that provided standards for certificate of public convenience and necessity for life support and air ambulance services. It also provides for the filing of an appeal by an applicant to be brought before the Circuit Court with jurisdiction over the county and applicate. In theory, this would remove control of COPCNs from county government to the courts.
* Senate Bill 664, physician orders for life-sustaining treatment (P.U.L.S.E.): provides direction for hospice and other health care for life-sustaining treatment and palliative care situations.

Mr. Skavroneck then stated on the Agency for Health Care Administration (AHCA) held a rule-making workshop on October 28 in Tallahassee to review proposed policies and replace language within the Medicaid ambulance handbook.

Another rule-making workshop would be held on November 20 in Tallahassee to address changes to 59G-1.010, 59G-1.050, 59G-1.051 and 59G-1.053. This pertains to definitions, general Medicaid policy, dually eligible recipients (Medicare and Medicaid) and authorizing requirements. On a federal level, ICD 10 codes became mandatory for all reimbursement claims with dates of services effective October 1.

Data Committee:

Chief Donatto reported that the main area of focus was reporting data back to providers, as well as developing a business front-end that’s going to give providers much more access to that data. The number of providers that reported on a voluntary basis has increased and there are still a couple of large counties that soon will join. This would dramatically increase the amount of patient records.

Chief Donatto stated there were concerns about the upcoming Version 3 data set that will soon be mandated to be used by all providers that are participating by December 31, 2016 because no provider had been validated to submit the data. The concern was ensuring they had an adequate supply of vendors to meet the needs of the entire state EMS community while maintaining low costs.

In regards to vendors being approved for the Level 3 process, Chief Donatto explained that for Florida, not one has been validated for submission. They are in the process for it but are not yet validated.

Mr. McCoy added that the Data Committee did a lot of work on it the first go-round, with the help of feedback from the committee and constituents, that when an agency buys software that meets certain standards. The verification process was created to ensure that when they come to Florida, they get what they pay for. Even on a national level, there was not many who are going with the 3.0 product just yet. He stated that in order for things to start happening more quickly, it would be up to the committee to finish because they had already done everything they could do on their end.

Chief Donatto stated that all government agencies will begin their budget process in the February/March timeframe. If you did not have a vendor that you are satisfied with or one that’s going to meet the deadline, you have to start funding those things in soon as possible. He agreed that it would most likely take more time because there would not a lot of vendors to choose from during the February/March timeframe.

Access to Care Committee:

Jane Bedford reported that a workshop was held the previous night. The committee is currently working on helping EMS systems make their community paramedicine more sustainable. It is a huge project and was causing a lot of problems but they do know that partnerships with EMS programs and their community partners are essential to the success with those programs.

Chief Frank Babinec and Juan Cardona from Coral Springs Fire Department both gave presentations. They have an active community paramedic program and they are beginning stages of a Mobile Integrated Healthcare Provider (MIHP) partnership with Cleveland Clinic.

Dixon Marlow from Amerimed Medical Solutions, Reg James from Home Physician Care and Michael Coleman from Grady EMS Atlanta, Georgia also presented on various programs offered in Georgia and other states. They have been running these programs since 2008.

Disaster Response Committee:

Dr. Lozano reported that the Bureau of Preparedness and Response provided a review at their meeting yesterday. Despite the personnel changes made, the bureau is still doing just fine. A point was made that health care coalitions still remain viable and the primary vehicle for what used to be Health Resources and Services Administration (HERSA) funding and EMS agencies are encouraged to engage within their regional coalitions.

The tourniquet is being promoted through the health care coalitions. SMART teams continue to be funded as well. Dr. Lozano presented items that were demonstrated at the Disaster Response Committee meeting. The first was a small pencil case that is used as a bleeding field response kit. He stated that 70 kits were prepared and distributed throughout the county. They are adjacent or attached to the AEDs in county facilities. County employees were trained on how to open them up and deploy them. The kits contain a tourniquet and an anti-clotting mechanism. It got the attention of the White House and the teams were invited to a hold a campaign called “Stop the Bleed,” which is being promoted through the Department of Homeland Security.

Dr. Lozano then presented a shrink wrapped packet. It was designed as a self-aid or buddy aid. It contained a Stretch-Wrap-And-Tuck (SWAT) tourniquet, a chest seal and another bleeding control agent. It was sized to fit underneath the chest plate of a ballistic vest.

The third item demonstrated was a multiple event capable MCI bag with contents. The contents are listed on the Fire Chiefs website. There was also a demonstration on the seventh version of the Combat Application Tourniquet (CAT).

The Disaster Response Committee distributed a cross-walk comparison of the START, JumpSTART and SALT trauma triage. The emphasis was on the similarities so that the agencies may use them for training purposes.

Dr. Lozano reported that “active shooter” is now called “active assailant” due to it usually being a group effort and not just one individual. He recently attended the American College of Emergency Physicians Conference held in Boston. Several providers gave presentations on how to handle victims of IEDs and active assailants. Health care agencies and hospitals are soft targets and they need to thoroughly understand that. They must work with their law enforcement on ways of securing both their emergency departments and operating suits in the event of an attack.

Dr. Brad Elias, Medical Director, Bureau of Preparedness and Response, then presented on infectious disease transport network. He stated that he would like input from the EMS community and those who would like to participate as part of providers in that network. Post 2014 Ebola outbreak, the federal government created those regional transport centers. Those centers are capable of providing a high level of care to varying and highly infectious patients. With that in mind, the states are responsible for getting patients to those treatment centers.

The Bureau of Preparedness and Response has been working in collaboration with their counterparts in FEMA Region 4 states. Their primary means of moving patients is by air—fixed wing assets used the vendor Phoenix Air based out of Atlanta. They have three G3 Gulfstream jets that are capable of this highly infectious mission. The bureau has looked into a back-up plan using ground assets. Originally the plan was to use a single source or single EMS provider to provide that inner facility transport from hospital to treatment center. However, after two Request for Interest Proposals, the feedback was limited. It was determined from that feedback that the concept wasn’t financially feasible.

In collaboration with the RDSTF health and medical co-chairs and leadership from the DOH, the FFCA and the State Fire Marshall’s Office, the model is shifting from a single provider to a regional approach. They asked the agencies to provide them with at least ten personnel that were willing to be trained and to have two vehicles at the time of an activation. In return, by signing a memorandum of understanding with the state, the state would provide the in-depth training, additional personal protective equipment and some financial reimbursement.

Dr. Elias stated they the bureau is working on insurance issues related to the COPCN, medical direction and other means of reimbursement. They are in the planning stages of creating an interstate plan for moving patients. The Disaster Response Committee discussed how they could try to limit the number of turnovers and handoffs of the patient.

Dr. Moreland then made a motion to adjourn the meeting. The motion was seconded and the meeting was adjourned at 3:00 p.m.