



## **The National Emergency Medical Services Advisory Council (NEMSAC)**

September 17-19, 2019

Grand Hyatt Hotel, Tiber Creek Rooms A&B

1000 H Street, NW

Washington, DC 20001

**Tuesday, September 17, 2019**

### **Call to Order, Introductions, and Opening Remarks**

*Vincent Robbins, NEMSAC Chair*

Mr. Robbins called the meeting to order at 9:00AM.

### **Opening Comments**

*NHTSA Designated Federal Official, Jon Krohmer, MD, Director, Office of EMS*

Dr. Krohmer welcomed NEMSAC members and public attendees. He noted that this is a federally recognized meeting for the National Highway Traffic Safety Administration (NHTSA) and added that Heidi King, Deputy Administrator, retired from NHTSA and James Owens was named as the new Acting Administrator and new Deputy Administrator 2 weeks ago.

NEMSAC members introduced themselves.

Public attendees introduced themselves. No one was participating via webcast.

### **Approval of July 9 - 11, 2019 NEMSAC Meeting Minutes**

Mr. Robbins asked for comments, discussion, or deletions to the current July 2019 NEMSAC meeting minutes. Seeing none, he asked for a motion to approve them. A motion was made and seconded. The minutes were unanimously approved.

## **Federal Liaison Update**

*Department of Transportation (DOT)*

*Jon Krohmer, MD and Office of Emergency Medical Services (OEMS) Staff*

Dr. Krohmer shared that the DOT is continuing to receive EMS 2050 program feedback and he will update the team this afternoon during the committee reports. The position vacated by Jeremy Kinsman is still being processed through human capital, and he is hopeful that it will be posted in next few weeks. The position of Associate Administrator for Research and Program Development is also vacant and working its way through human capital.

*Department of Homeland Security (DHS)*

*Duane Caneva, MD, Chief Medical Officer, Countering Weapons of Mass Destruction Office*

Dr. Caneva was not present and a report was not provided.

*Department of Health & Human Services (HHS)*

*Lt. Charley Hammel, RN*

Lt. Hammel was not present and a report was not provided.

*Health Resources and Services Administration*

*Diane Pilkey, Emergency Medical Services for Children (EMSC), Senior Nurse Consultant*

Sam Vance, MHA, LP from the EMSC Innovation & Improvement Center provided the report on behalf of Ms. Pilkey. Nine states currently have pre-hospital learning collaboratives (PECs). They are working towards the goal of establishing 360 new PECs within 6 months of the collaborative, and as of August 23, 2019 they had reached 92% of the goal. All 50 states and US territories can participate in the program and resources are available for recruiting and educating PECs. The original 9 states have reached 142% of the goal and have recruited a total of 565 PECs.

The National Pediatric Readiness Project is focused on improving emergency department pediatric readiness. The project began with a focus on EMS identifying a pre-hospital readiness steering committee. The team is currently working on a project charter and discussing the development of tool kit. They are planning to conduct a nationwide EMS assessment of Federal EMS agencies in 2023.

Established EMSC performance measures include:

- Establishing a pediatric EMS coordinator within each federal agency
- Ensuring that all agencies have pediatric equipment (this measure has been met).

The next initiative will be to assess if individuals know how to appropriately use the equipment and what education and training is needed. The National EMSC data analysis

resource center in Salt Lake City, UT will begin the process of annual assessments in January 2020.

### *Mental Health and Wellness*

*CAPT Scott Salvatore, US Public Health Service (USPHS), Board Certified Psychologist/EMT, Department of Homeland Security (DHS)*

*AST2 Joseph Glaser-Reich, Helicopter Rescue Swimmer, U.S. Coast Guard*

CAPT Salvatore proposed a paradigm shift in EMS personnel mental health and wellness towards health promotion, primary prevention strategies, resilience and performance enhancement interventions. A 2015 study highlighted the state of mental health and noted that 37% of EMS practitioners surveyed endorsed contemplating suicide. In Arizona, EMTs have double the rate of suicide compared to non-EMTs. A National Association of Emergency Medical Technicians survey reported that 37% of EMS agencies do not have any mental health support services and 42% did not have any health and wellness services. Post-traumatic stress disorder (PTSD), depression, stress, exhaustion, and substance abuse are all concerns among first responders. The cumulative impact on EMS personnel includes an increased risk of CVD, higher risk of coronary events, low fitness, weight gain, obesity, early retirement, and premature death. CAPT Salvatore emphasized that more integration of mind and body health is needed to improve the success of initiatives.

A stigma exists and support is lacking for those returning to work after a traumatic or critical incidence. EMS personnel are generally dissatisfied with the level and types of agency support available. Employee assistance programs (EAPs) are not providing ongoing long-term care and individuals must rely on their private health insurance.

Mr. Kaye asked if adequate information or access to data exists on the types of mental health challenges within the EMS provider community? CAPT Salvatore shared that the National Action Alliance for Suicide Prevention has a task force to look at public safety worker's and law enforcement, but they are also working with Centers for Disease Control (CDC) to try and collect more accurate data. He added that more complete and accessible data existed within the military compared to the EMS system.

CAPT Salvatore highlighted that it will be key to shift organizational factors that encourage help seeking and approaching supervisors. He stated that over 99% of individuals in the DHS with psychological conditions obtain or retain their security clearances, a common myth and barrier to seeking help. In 2017, the military changed the SF-86 security clearance questionnaire and applicants no longer need to list whether they are in counseling, or have depression, PTSD, or anxiety. The most severe psychological conditions (i.e., schizophrenia, personality disorders) still must be disclosed. He challenged leaders to work diligently to change what has long been a strong part EMS culture. He proposed the following strategies:

- Leaders within EMS agencies must establish credibility by sharing their own personal stories and challenges, how they sought treatment and then champion that behavior among personnel,
- Disseminate information in a consistent and sensitive way.

Mr. Glaser-Reich continued and explained how the military is addressing similar challenges. He shared that US Customs and Border Protection has a director of resiliency programs and has comprehensive resilience programs for staff. The training program includes mental, physical, social and spiritual domains. The Uniformed Services University has developed the SOCAT Program which aims to enhance cognitive ability and problem solving to facilitate dynamic, decision-making and adaptation to life changes. Both programs are new, and data collection is underway. He also shared an example of the US Navy Recruit Training Command Warrior Toughness Program in Illinois which is a complete integration of resilience training into new recruit training. The curriculum was put together by a chaplain, psychologist and SEAL to help define 'toughness' and 'warrior'. The 1-year program has demonstrated lower recruit attrition and improved performance (higher swim test pass rate).

Currently, DHS is conducting a Mindfulness Pilot Case Study with the purpose of supporting and enhancing DHS workforce resilience, health and performance through evidence informed training that maximizes personnel readiness. Goals of the program are to increase resilience, mindfulness, stress management skills, quality of life and occupational and operational performance. More than 700 publications exist on the empirical evidence on the value of mindfulness. It has documented return on investment and is currently taught in:

- The US military (Marine Corps, Navy, Army, Special Operations)
- Corporations (i.e., Google, Nike, Apple, Intel, etc.)
- Universities (i.e., Duke, Stanford)
- Training programs for high performing athletes and sports teams
- Training programs for law enforcement and first responders

Mr. Glaser-Reich noted that current barriers to the implementation of such programs include:

- Securing funds, reallocating current funds
- Obtaining buy-in from the organization
- Obtaining buy-in from senior leadership and ground level staff.

His group will be evaluating psychometrics on their current program and adjusting future training, as needed.

The 2017 Law Enforcement Mental Health and Wellness Act compared Department of Defense and Veteran's Administration Health and Wellness Programs. Based on the assessment, they are expanding peer mentoring programs and crisis line services.

Mr. Powell pointed out that states are inconsistently covering mental health worker compensation. Mr. Garrett advocated for creating state PTSD laws that would support mental health conditions that are occupationally related. Others are concerned that this information is being weaponized during the promotion process which hinders participation and help seeking.

### **Trauma RFI Review**

*Mary Fallat, MD, Hirikati S. Nagaraj Professor and Chief, Pediatric Surgery, University of Louisville School of Medicine*

The task force, including Dr. Fallat, Dr. Adalgais and Mr. Tobin, was looking to align the Model Trauma System Planning and Evaluation (MTSPE) document with the 2016 National Academies of Sciences, Engineering, and Medicine (NASEM) National Trauma Care System Report. The goal was to achieve zero preventable deaths. Currently, the document does not contain geriatric or pediatric metrics.

FICEMS took the beginning of the continuum (EMS) to assess how prehospital trauma care could be improved. On April 27, 2018, NHTSA, on behalf of FICEMS, posted a Request for Information (RFI) in the Federal Registry on the document, *Improving Prehospital Trauma Care*. Twenty-six responses were received and were organized into categories for the task force to address. The task force then worked to determine the need for white papers, NEMSAC advisories and areas that could be immediately implemented. Themes and related task force plans included:

- Clinical Care Themes: outline standards and criteria for priority triage of different ages of patients in individual and mass casualty scenes
- Data and Measures:
  - Implement evidence-based guidelines for all aspects of trauma care, with integration across organizations and a central website or repository of guidelines
  - Deemphasize competition between states and emphasize quality improvement and best practices
  - Integrate pre-hospital systems with hospital electronic medical records and motor vehicle crash telematics
- Notification and Communications:
  - Utilize technology to ensure seamless communication between all responders, including 1<sup>st</sup> and 2<sup>nd</sup> response teams, police, and trauma centers
  - Address communication in rural and austere environments which are resource poor
- Research: develop a national trauma research action plan as currently no National Institutes of Health (NIH) institute is specifically allocated to this area of research
- Governance and System Design: recommend model curriculum and rules for state licensure for medical dispatch center personnel that is centered around the topic of trauma
- Military Integration:
  - Identify educational gaps between field military and civilian providers

- Introduce a training center of excellence to bridge educational gaps and transition military medics into the civilian system
- Education and Training: the task force strongly recommended loan forgiveness for provider education/training for those who go on to work in tribal EMS and rural areas

The task force's summary may inform a white paper, which would be contracted by NHTSA and/or FICEMS.

Mr. Kaye asked if there had been discussion about how we can capture the pre-hospital information in real time so that it is useable on the scene, available to emergency department (ED) staff and available to make patient treatment decisions. Mr. Robbins responded that a proposal has been submitted to examine challenges of implanting a real-time system.

Ms. Bartram expressed concern that 911 cannot locate trauma event in certain rural areas. Ms. Montera said that the group recognizes the challenge and is taking additional time to examine how best to deal with the gap.

### **Public Comment**

Mr. Robbins asked if any members of the public wished to speak. No one present at the meeting or on the webcast addressed the Council with questions or comments.

### **CMS Emergency Triage, Treat and Transport (ET3) Model**

*Carlye Burd, Center for Medicare and Medicaid Innovation (CMMI)*

Ms. Burd is the ET3 team lead and provided the update to the Council. Since the last meeting, the group released a Centers for Medicare and Medicaid (CMS) Informational Bulletin to develop guidance for states who would like to implement ET3. It details some considerations states may wish to look at, and is a novel guidance for CMMI in that it provides states with a framework for the implementation of a model. They are continuing to provide presentations to Medicaid Directors to better help them understand what is in ET3, and how to work with CMS.

#### *Integrating ACOs with ET3*

The team has also provided guidance on how Accountable Care Organizations (ACOs) and other entities responsible for total cost of care can integrate with ET3. Guidance allows for non-911 calls to respond via ET3 if the call first comes through 911. The ET3 model is specifically modeled around the use of 911. (<https://innovation.cms.gov/initiatives/et3/faq.html>)

#### *24/7 Policy Clarification*

The team had received feedback from stakeholders that the 24-hour requirement through ET3 was the reason many ambulance providers were not applying for ET3. She stated that an

applicant can apply and propose a plan for an alternative destination or alternative treatment provider. If the proposed plan is feasible, then the committee would still consider that the applicant met the 24/7 requirement. Services may decide to form collaborations in order to provider that 24/7 coverage, and the committee is aware that it may take time to establish and set up partnerships. Applicants need to provide details of their proposed plan and the estimated time frame for implementation. These adjustments in the applications were made to ensure the 24/7 policy was not preventing applicants from applying if they didn't currently have a 24/7 policy in place at the time.

Mr. Washko shared that his region has annual contracts with transportation providers and asked whether the program would tailor start dates to coincide with individual start dates. Ms. Burd asked that applicants provide that information in their applications, but they will not be individualizing start dates. The group wants to be sure that they are ready to receive payment on January 1. Participants will not be penalized or prevented from participating if they do not estimate payment on January 1. If additional space is needed on the program application, applicants should email ET3 directly. Supplemental documents will not be accepted attached to applications. She provided updates on specific topics related to ET3.

#### *Application Clarifications*

ET3 encourages applicants to take a regional approach and collaborate among providers and health systems. The agreement creates relationships with CMS and ambulance providers at the National Provider Identifier (NPI) level. She recommended opening an account using the application portal and submitting an application for each NPI. Applications may contain the same information, but each NPI needs its own application.

Ms. Montera asked if applicants need all of the NPIs at the time that the application is submitted. Ms. Burd responded no, and shared that they will do vetting on the providers and will provide applicants with a list of approved providers. Applicants may then proceed with their collaborations and subsequently add or subtract providers from their list. This will be an ongoing process and does not need to be done all at once. They are currently in the process of determining how often to update the provider list.

#### *Treatment in Place Provider Clarifications*

Treatment in place (TIP) providers are Medicare enrolled and licensed providers. However, state laws and practices determine who may provide TIP services on-site or via telehealth. If a provider is licensed to provide TIP care then they may participant in the model if they act in compliance with their specific state laws.

#### *Telehealth Connectivity Clarification*

If a connection drops while a provider is in the process of providing telehealth, they may bill for the telehealth encounter if it is 'substantially complete.' Telehealth providers are asked to use their best clinical judgement.

### *Triage Decision Clarification*

If an ambulance arrives on the scene and in the process of making triage decisions they consult a medical provider, that consultation is not billable and does not count as TIP. ET3 is designed such that the ambulance supplier is the provider of triage decisions. Ambulance providers may consult with a provider at the ED, for example, but that provider consultation may not be billed. They were 'consulted' in this scenario. Additionally, the fees associated with telehealth services will all remain the same under the Medicare physician fee telehealth schedule. An upcharge during non-business hours is permissible.

### *'Multiple Billing Per Encounter' clarification*

During a single 911 call where TIP is initiated, if the patient's condition deteriorates and it is decided that the person needs to be transported to the ED, the triage decision is made and then billed under the ambulance provider. If the patient needs to be transported, the ultimate service (transport) is what may be billed. Both TIP and transport may not be billed.

The ET3 team had an ED physician member who is compiling a list of scenarios where transport to alternate destinations will be necessary. Unique codes will exist for 'transport to ED' vs 'transport to an alternative destination.' The use of the appropriate code should prevent the unnecessary denial of claims.

Dr. Washko asked if medical necessity will apply to the decision-making process when determining whether to transport patients to an ED or an alternative destination. Ms. Burd clarified that TIP services must meet Medicare medical necessity requirements like any other service provided and requested for payment from Medicare. Billing instructions and unique modifiers will be sent directly to those enrolled in ET3.

ET3 requires that ambulance providers take patients to facilities that accept Medicare so that patients do not end up with a large bill.

## **FirstNet**

*Brent Williams, FirstNet, EMS Senior Advisor*

Mr. Williams described the FirstNet system and emphasized that it is part of the US Department of Commerce. He is the Senior EMS Advisor on the team and a federal employee.

He explained that FirstNet is the national public safety network and the group acts as the advocate for US public safety. The 911 attacks emphasized the need for a federally coordinated emergency communication system. All public safety communications were voice only at that time. In 2012, Congress passed legislation establishing the need and funds for the FirstNet system; \$7 billion and 20MHz of spectrum were allocated for an LTE network. The mission of the project was the establish, operate and maintain an interoperable public safety broadband network.

From 2012 to 2016, FirstNet worked with the state and territory governors' offices to gather information about what they envisioned for the system and how it could meet their needs. In 2016, a detailed request for proposals (RFP) was released and AT&T was selected as the best value proposition. AT&T is in the process of building a dedicated FirstNet public safety core that runs the network as legislation instructed. FirstNet has a separate network ID number that shares current AT&T towers. The contract includes an ongoing 5-year build out to provide AT&T coverage to areas currently not covered. If a tower site (hardware) is filled or overloaded with commercial users, the FirstNet devices are designated as high priority and will get access to the system. All 50 states, 5 territories and the District of Columbia are enrolled. (FirstNet.gov/Roadmap) A 25-year contract exists for AT&T to manage and maintain the network for the federal government.

The FirstNet system will provide:

- Location services, cameras/video, mission critical push-to-talk (MCPTT)
- Secure information exchange: data access and sharing, cybersecurity, identity management/single sign-on
- Two-way video from patient/EMS scene to the hospital/physician
- Support communication needs of new Community Paramedicine programs

Whole EMS systems or a single agency may enroll. First Net offers a subscriber paid system for cell phone users/EMTs/Paramedics if smaller areas or agencies cannot support the program. Users pay a monthly subscription that is at or below commercial AT&T services and provides all the FirstNet services. AT&T has specialists who manage the set up the accounts.

Mr. McMichael asked about the strength of coverage during severe storms and along shorelines. Mr. Williams explained that the AT&T response operations group can deploy coverage to key areas, such as along the path of a hurricane. Drones are also being employed to harden the network and increase its resiliency during disasters.

Ms. Lubogo asked if the individual FirstNet subscriptions are accompanied by training. Mr. Williams shared that no training is included and that the service works similarly to any other cell service. Subscribers utilize whichever Apps they need to provide emergency services.

## **Public Comment**

Mr. Robbins opened the floor for comments from members of the public attending the meeting or joining via webcast.

Mr. David Becker, Past Chair of the EMS section for the International Association of Fire Chiefs (IFC) provided comments regarding EMS degree requirements. He stated that the IFC has taken a definitive stance against the requirement for an associate's degrees for EMS personnel. He shared that EMS

professionals can operate at a high level of performance whether they have a college degree. Currently, paramedics complete state accreditation programs. All accreditation programs provide a pathway to obtain an associate's degree if an individual chooses to pursue that. The bar for education was raised in 2013 when graduation from an accredited paramedic program became mandatory. He is not aware of evidence that exists to show that paramedics with an associate's degree perform better or improve patient outcomes. Additionally, paramedics with an associate's degree or a certificate will be working in similar jobs. He summarized by saying that the current draft timeline for requiring paramedics to obtain an associate's degree is overly aggressive and likely unattainable. Not all 50 states have yet adopted the requirement that paramedics attend an accredited paramedic program. He feels that degree requirement will worsen the current paramedic shortage.

Mr. Robbins and Mr. Tobin encouraged Mr. Becker to attend the Preparedness and Education Committee meeting to discuss his thoughts in more detail. Mr. Robbins pointed out that this Council does not issue rules and regulations. The committees make recommendations to the DOT. Committees are intended to be informative and aspirational.

## **Review of Ongoing NHTSA Projects**

### *Nomenclature Project Update: David Bryson*

Discussion has been ongoing about whether to use the term 'EMS' or 'paramedic' to describe EMS providers. The group is working with HRTSA and author Michael Gerber from RedFlash group to draft a white paper. The draft is near completion and it will be posted for public comment from the national EMS community in approximately 2 weeks. Summary points from the white paper include that:

- Members of the EMS community are not ready to eliminate the use of the term 'EMS'
- Additional discussion is needed to determine how to use the term 'paramedicine'
- Clinicians did not agree to call all clinicians who provide emergency services 'paramedics'.

Mr. Robbins reiterated that the NEMSAC advisory is seeking a term that would be applied universally to individuals who provide emergency care.

### *Update on the National EMS Education Standards*

The first version of the educational standards document was put forth several weeks ago with a deadline of September 20, 2019 for organizational comments. The group will summarize the comments and meet again on October 3-4, 2019 at the DOT. All national EMS organizations will be present to comment on the standards and review the comments. The document will be updated and the team will begin discussing the instructional guidelines. They will also publish for comment from the EMS community 5 possible options for instructional guidelines in the next few days. The goal is to have the project completed by May/June 2020.

### *911Program: Laurie Flaherty*

Kate Elkins from the NHTSA Office of EMS provided the update on programs on behalf of Laurie Flaherty.

The National 911 Program issued \$90 million in grants to 33 states, DC and 2 tribes on August 9, 2019 to help assist with technology upgrades to the Next Generation 911 program. This will update public safety answering points (PSAPs) to a digital or Internet Protocol (IP)-based 911 system ([www.911.gov](http://www.911.gov)).

CPR Lifelinks is a collaboration between EMS agencies and PSAPs to do high performance CPR in the field and to work to improve telecommunicator performance. An additional aspect of the collaboration is to allow survivors to meet the EMS providers who cared for them. A Tool Kit is available to for those who wish to adopt the practice that was done in Bend, OR ([www.911.gov](http://www.911.gov); EMS.gov).

The American Heart Association (AHA) has approached state legislators about CPR field and telecommunicator training. The National 911 center can connect individuals with their legislators so that 911 and EMS stakeholders can be involved in programs related to CPR outcomes.

Mr. O'Neal shared that states have been asking for regulations to standardize telecommunicator training. Mr. Robbins explained that NHTSA does not regulate community agencies and that 3 proprietary software makers currently provide telecommunicator training.

Ms. Elkins added that many layers to the 911 system exist and analog systems cannot interact with digital or IP systems. Additionally, 60% of PSAPs are staffed by only 2 individuals which creates challenging workforce and technology environments when more than 2 calls come in at a time.

### *NEMSIS Update*

*Eric Chaney*

Mr. Chaney provided an update on the information that has been received to date into the NEMSIS database. Forty-five states currently collect Version 3 software and report it to the national database. Five states use Version 3, are not currently submitting reports, but will hopefully go online in the next 12 months. The addition of validity rules to Version 3 has created better quality data, but some errors remain which are being investigating and will likely be addressed in Version 3.5.

Currently, 31 million records have been collected in 2019 (some are 2018 records) and the closed 2018 data set contains 22 million records. Data sets are available and can be sent out on

a thumb drive to those interested. Over 100 articles have been published on Google Scholar utilizing the data.

He shared that compliance testing of NEMESIS Version 3.5 will begin shortly. The department has extended the availability of Version 3.3.4 until March 2021 at request of state data managers to accommodate those who wish to transition directly from Version 3.3.4 to 3.5.0. Data will be migrated from the University of Utah hosting center (NEMESIS.org) to a federal hosting center (NEMESIS.gov).

On January 29, 2020, the National Security Council, along with NHTSA and OSC, will host a data integration summit in Washington, DC. An announcement will be made in October 2019 to engage interested parties in the summit.

Mr. Robbins asked that Council members provide Mr. Chaney with draft advisories so that they can be presented to the rest of the Council during the meeting for comment. He emphasized that the general public are welcome to attend the committee meetings. He also asked that the meeting tomorrow convene at 8:30am. He adjourned the meeting at 3:42pm.

**Wednesday, September 18, 2019**

Mr. Robbins opened the meeting at 8:30am.

### **Introduction of James Owens, Acting Administrator, NHTSA**

Mr. Robbins introduced James Owens who began in the role of Acting Administrator of NHTSA 2 weeks ago. Mr. Owens expressed that he is looking forward to figuring out how to best support the work of the NEMSAC Council and thanked the group for their work along with the work of the entire EMS community.

Mr. Robbins thanked Mr. Owens for coming to meet the Council. Ms. Montera thanked Council members and reminded participants that they represent their sectors and should practice due diligence in their committee work.

### **Ambulance Crash Investigation**

*Harold Herrera, Special Crash Investigators, DOT, Team Lead*

Mr. Herrera explained that Special Crash Investigations (SCI) is the NHTSA rapid response team for NHTSA and was established in 1989. Their work is divided into 3 regions within the US: Eastern, Central and Western and they investigate approximately 100 crashes of interest each year. Most of their work is for the Office of Defects Investigation (ODI) and all technical final case reports are available to the public ([www.Crashviewer.nhtsa.dot.gov](http://www.Crashviewer.nhtsa.dot.gov); www.EMS.gov).

In 2011, the National Institute for Occupational Safety and Health (NIOSH) contracted with SCI to investigate ambulance crashes. The team has investigated 60 cases since then with an approximate cost of \$10,000-18,000 per investigation.

Factors involved in determining whether an ambulance crash should be investigated include whether:

- the ambulance was in traffic
- fatal injuries in the ambulance occurred
- the crash was potentially survivable
- a cot retention failure occurred
- an incapacitating injury in patient compartment occurred
- the ambulance rolled over
- operator fatigue may have been a factor.

The office of EMS determines whether to investigate and if resources exist. Information on the occurrence of crashes comes primarily from the internet, google alerts, emails and phone calls.

Mr. Herrera shared a report from a crash involving a 2009 Ford E-350 truck and a type II ambulance in New Mexico. The ambulance contained 7 occupants and the cot was outfitted to transport a premature infant in an incubator. Five individuals were in the back including the infant, mother, two nurses and an EMT. Weather and speed did not appear to play a role in the crash. The driver of the Ford could not see the ambulance through the intersection because of an overpass. The ambulance rolled over in the crash, but did not sustain severe damage. The driver of the Ford E-350 was other vehicle involved, driver did not sustain any injuries. The top mounted access door opened, the incubator was ejected from vehicle and the infant was ejected from the incubator. An RN located the 6-week-old and began emergency breathing procedures. The patient suffered bilateral intraventricular hemorrhages and pneumothorax and was airlifted to hospital for emergency surgery. The infant expired 28 days later likely due to preterm birth. No autopsy performed and cause of death unknown. Several ambulance passengers on the bench in the compartment sustained C type injuries.

Mr. McMichael proposed that the extra weight of the 7 passengers may have contributed to the longer stopping distance and suggest that ambulance manufacturers impose weight limitations.

Mr. O'Neal asked Mr. Bryson if the SCI attempts to establish cause in the crashes. He responded that they conduct an analysis of the crash and capture data but do not direct any cause or blame. Often cases are closed if ongoing civil litigation exists since involved parties stop cooperative with our efforts. Our goal is to examine the data in aggregate and try and determine any modifiable elements that may have prevented or lessened the severity of the crash or injuries.

Mr. Krohmer asked if law enforcement is mandated to report crashes involving ambulances. Mr. Herrera clarified that the burden to activate an investigation lies with the ambulance agency.

Mr. Kaye asked if the crash data is searchable online. Mr. Herrera explained that individuals may query crashes by state and see the technical report, SCI report and images ([www.Crashviewer.nhtsa.dot.gov/SCI/Searchindex](http://www.Crashviewer.nhtsa.dot.gov/SCI/Searchindex)). Mr. Bryson added that the data will also be available on EMS.gov soon.

Mr. Baird asked whether the incubator manufacturer was notified since the crash involved the functionality of their product. Mr. Herrera explained that since SCI does not regulate that type of equipment, it currently does not report incidences to manufacturers but noted that it sounded like a good idea to consider doing so in the future.

Mr. Robbins adjusted the agenda and Mr. O'Neal was asked to present his committee's advisory for final approval.

## **NEMSAC Committee Reports**

### *Professional Safety Committee*

#### Opioid Exposure EMS PPE Recommendations

Mr. O'Neal recapped that this advisory is intended to provide guidance to EMS professionals regarding potential exposure to complex opioids (i.e., fentanyl) in the field. The advisory received interim approval at the July 10, 2019 meeting. Minor formatting changes and additional citations were included in this updated version.

He highlighted that the advisory was created in response to the recent sensational reporting in the media about opioid exposure by EMS personnel. Several organizations have since released conflicting guidance documents. NEMSAC felt that the organization should provide training information to EMS providers that summarizes evidence-based best practices. The committee made the following recommendations:

1. Education on personal protective equipment for potential opioid exposures should be incorporated into the EMS educational standards and instructional guidelines
2. Education should be included in routine continuing education programs of EMS providers via Learning Management System Modules, or other modalities
3. Training information should include the scientific evidence from the American College of Medical Technology (ACMT) and American Academy of Clinical Toxicology (AACT) position statement: Preventing Occupational Fentanyl and Fentanyl Analog Exposure to Emergency Responders (2017).

Further, the advisory recommends personal protective equipment use by EMS professionals.

Mr. Robbins asked for a motion to make this the final advisory. Mr. Powers made a motion and Mr. Washko seconded the motion. With no additional questions or comments from Council, the advisory unanimously passed.

Dr. Krohmer announced that NHTSA is conducting a media event on September 19, 2019, during Child Protective Safety Week, focusing on child protective safety issues. Topics will include the appropriate use of positioning of car restraints and the issue of leaving children unattended in vehicles and the related heat illness issues and deaths. This year saw the largest number of reported pediatric heat illness deaths related to hyperthermia from being inside vehicles. Each death is discussed at the daily NHTSA leadership meeting. He shared that NHTSA will be announcing a very aggressive campaign to continue to educate the community about the risks. Vehicle manufacturers will also be including new monitoring devices in vehicles by new model year 2025. Larger retail establishments, including restaurants will be partnering and posting posters and notices. This provides an opportunity for EMS agencies around the US to get involved in their communities to raise awareness about heat illness and exposures.

## Public Comment

Mr. Robbins opened the public comment portion of the meeting.

Mr. Rob McClintock from the International Association of Fire Fighters expressed the organization's opinion that a non-college educational and affordable path to becoming a paramedic remain. He clarified that they are not opposed to education at any level, but are opposed to an associate's degree being the mandatory requirement for entry level positions. Having several options for becoming a paramedic would permit Individuals to choose the pathway to become a firefighter that best suits their needs, and the needs of their families.

On behalf of the committee heading up the advisory on paramedic education, the advisory chair will remove the word 'mandatory' from the committee recommendations on an associate's degree. She invited Mr. McClintock to the committee meeting this afternoon emphasizing that the committee would like to work towards a mutually agreeable compromise.

Ms. Dia Gainer, the Executive Director, National Association of State Emergency Medical Services Officials (NASEMSO), reported that a CDC publication in 2017 indicated that the ambulance crash rate is 2.5 times higher than that of passenger cars. She is concerned about the absence of ambulance crash standards when more than 1.6 million patients are transported by ambulance every year in the US. She pointed out that ambulance manufacturers do not have an objective basis for establishing safety criteria in their vehicles. Guidelines from NHTSA published several years ago do not contain physical crash testing criteria. NIOSH funded the process to determine how best to restrain equipment such as an ECG monitor in the back, for example, but it does not appear that they are going to fund similar physical crash testing for pediatric safety restraints. Her organization is concerned that heightened attention is not being placed on this matter, and she appealed to the Council to advance appropriate recommendations.

Mr. Garrett shared that he sees ambulance manufacturers bolting stretchers into the ambulance floor, and agreed that a clear need exists to objectively evaluate the safety of all features in an ambulance.

Ms. Gainor added that the Society of Automotive Engineers published crash tests standards for restraints, but the expense to local and even larger EMS organizations creates a significant challenge to their implementation.

Mr. Washko motioned that the Equitable Patient Care committee to take up this topic and develop an advisory. He suggested it include recommendations for other safety features such as lights, sirens, and pediatric restraints, neonatal restraints, etc. Dr. Bradley seconded the motion. Mr. Robbins motioned to include the Data and Integration and Profession Safety committees on the advisory to research, investigate and make recommendations on neonatal

and pediatric restraints and crash test criteria. Dr. Bradley seconded the motion. The motion was unanimously approved by the Council.

Tristan North, Sr. VP of the American Ambulance association expressed the organization's opposition to a mandatory requirement for a college degree for paramedics. Such a requirement would exacerbate the nationwide paramedic shortage, and data do not appear to exist that demonstrate that mandating a degree would improve patient outcomes.

Mr. Tobin shared that the advisory is being updated during committee meetings this afternoon and invited Mr. North to attend.

No additional public comments were offered.

### **NEMSAC Committee Reports Continued**

Mr. Robbins informed the Council that they will not be taking action on these advisories, but will discuss each and field questions at this time.

#### *Profession Safety Committee*

#### Mitigation of Direct Violence against EMS Professionals

Mr. Matthew Powers presented the committee's recommendations on behalf of the committee that NHTSA:

1. Convene a summit to engage stakeholders and interested parties to discuss issues pertinent to workplace violence for EMS field personnel
2. Convene subcommittees to develop feasible recommendations for addressing data collection, education and mitigation strategies informed by the summit proceedings
3. Develop a strategy for monitoring subcommittee progress on implementing their recommendations and that they shall provide a semi-annual progress report to NEMSAC that will be made openly available
4. Utilize a data collection system in conjunction with the advisory titled: *NHTSA office of EMS as a Central Repository for all EMS Provider Safety and Wellness Data* for violence reporting.

Dr. Krohmer suggested that the Occupational Safety and Health Association (OSHA) be included in the working group even though they are not a statutory member of FICEMS.

#### Mental Health and Wellness for the EMS Provider and their Partners in Public Safety

Mr. Garrett presented on behalf of the committee and shared that the committee would like PTSD to be recognized and covered under worker's compensation for EMS providers. The committee recommended that NHTSA:

1. Convene and fund a summit on EMS provider mental health and wellness

2. Develop educational programs to inform federal and nonfederal EMS stakeholders on the appropriateness of including mental health illness due to job-related performance/function as a disability covered under compensation for EMS providers
3. Utilize a data collection system in conjunction with the advisory titled: *NHTSA Office of EMS as a Central Repository for all EMS Provider Safety and Wellness Data* for mental health reporting.

Mr. Robbins suggested that the committee work with the Integration and Technology committee on the topic of data collection.

#### *Integration and Technology Committee*

##### Connected and Automated Vehicle Implications for Ambulances

Ms. Dia Gainor presented on behalf the committee. She explained that advancing technology in passenger cars and trucks is not being examined for use in ambulances. The technology may need to operate in a different mode and react differently when emergency vehicles are nearby to help avoid collisions. Two vehicle manufacturers have proposed installing 'kill' switches, but that is not an adequate solution. The committee would like an equal level of research on this topic for vehicles with lights and sirens.

Dr. Krohmer shared that the DOT is aware of this issue and held collaborative meetings with auto manufacturers in July and September 2019. Discussions have included EMS, law enforcement and towing industry vehicles. He encouraged the committee to continue their work forward, but with the awareness that support exists within the DOT.

The committee's recommended that:

1. DOT consider facilitating the coordination of federal resources
2. NEMSAC arrange one or more presentations to the Council by appropriate experts from the Federal Highway Administration (FHWA), Federal Motor Carrier Safety Administration (FMCSA) and Federal Transit Administration (FTA) to inform our group of the impact on EMS
3. NHTSA consider establishing relationships with and identifying opportunities to participate in connected and automated vehicles (CAV) related initiatives being led by other modal administrations and the Intelligent Transportation System Joint Program Office (ITS JPO)
4. The FICEMS committee on EMS maintain awareness about the rapidly evolving field of CAV and work to include EMS-specific needs.

##### NHTSA Office of EMS as the Central Repository for all EMS Provider Safety and Wellness Data

Mr. Kaye provided the committee report and summarized that provider safety and wellness is one of the most pressing concerns for the EMS industry. The committee recommended that NHTSA consider:

1. Collecting data from all federal agencies regarding pertinent EMS data, and hosting the data in one location within the NHTSA office of EMS to be easily accessible to all stakeholders
2. Expanding its current practice of providing static ambulance crash data into a robust system of data points that can be queried in multiple ways by stakeholders
3. Working with other industry professionals that are currently capturing episodic events such as E.V.E.N.T, and Firefighter Near Miss to collect usable information
4. Working with stakeholders already collecting data regarding violence against EMS personnel to create a more robust and active data set that can be utilized to track incidents and educate leaders on the scope of the problem
5. Working with engaged stakeholders such as the Code Green Campaign and the South Carolina F.A.S.T team to create a meaningful database of mental health and wellness information

#### *Adaptability & Innovation Committee*

#### CMS Reimbursable EMS Delivery Models

Chief Gale provided the committee update and explained that an opportunity exists to conduct additional analyses to examine how certain CMS rule and/or definition changes could increase potential EMS agency participation in these types of reimbursable EMS delivery models. If proven effective and efficient during the project, this may increase participation in different communities across the US, including some currently underserved rural and super rural areas. The committee wants to recognize that not all delivery models are in the current ET3 and that some agencies may not be able to qualify for reimbursement. The committee would like to ask Medicare to consider non-transport models for reimbursement.

Dr. Krohmer emphasized that he is not speaking on behalf of CMMI, but wanted to share that CMMI is very aware now of the issues raised in this advisory and discussions are ongoing. CMMI and the ET3 project is restricted on what it can do based on how the program currently exists, but the ET3 model has opened the eyes of CMS to better understand what EMS is. He feels that things are far from the desired end goal but he is very encouraged by our conversations with CMMI. CMMI is under restraints at this time based on the demonstration project.

#### Rural and Volunteer EMS Recruitment and Retention

Ms. Knight provided the committee report and stated that many agencies are having a difficult time recruiting and retaining quality EMS practitioners, especially in rural areas. The committee recommended that NHTSA consider:

1. Assembling a committee of subject matter experts to try and determine the root causes that impact agencies' ability to recruit and retain rural and volunteer EMS practitioners and study successful agencies to identify best practices
2. Compiling the committee findings into an online tool kit for rural and volunteer EMS agencies

Dr. Bradley noted that these issues are significant concerns and suggested that discussions should include EMS medical directors and emergency physicians from a variety of communities.

### Telehealth as a Strategy for EMS Care

Dr. Fallat shared that the committee incorporated information from FirstNet into this advisory, but wanted to point out that gaps in the AT&T telecommunication coverages exist, including the presence of audio but not video communication in some areas.

The committee recommended that NHTSA consider:

1. Expanding the use of telehealth during the ET3 project to include rural environments where the need for point-of-care services is often the greatest
2. Having CMMI collect information that would supporting using audio telehealth only ('hear and treat') in certain, algorithm-driven patients. Currently, telehealth requires two, way, interactive audio and video
3. Working with FirstNet to expand the network into those areas that currently have poor AT&T service (i.e., backcountry, extremely rural, and certain urban areas, etc.) to allow point-of-care telehealth services.

Dr. Krohmer shared that CMMI is very aware of the challenges in rural environments, but likely will not be able to change the pilot project to include rural areas. These are great ideas that should be put forward, but may be challenging within the current climate of CMMI and ET3.

Mr. Robbins cautioned that the Council and advisories should continue to put forward ideas the group feels are important, even it seems unlikely they will be implemented. The Council should continue to work with NHTSA and put forth the recommendations that we think are best. He asked the committee to continue working on the advisory and bring an update to the January 2020 Council meeting.

### *EMS Sustainability & Efficiency Committee* EMS System Financing Advisory 2019 Update

Mr. Garrett explained that the advisory is a succinct summary of the previous 2012, 2016 advisories on the same topic. EMS is a pre-hospital service and financing of EMS is fragmented and inadequate. The committee recommended that NHTSA consider, in coordination with FICEMS consider:

1. Supporting CMS efforts to implement and ensure accurate cost data collection from EMS services
2. Supporting efforts to update CMS regulations such that EMS is identified as a 'provider' type, enabling the establishment of conditions of participation and health and safety standards
3. Encouraging CMS to account for EMS agency under-investment due to the lack of financial recourses

4. Supporting efforts to make permanent the temporary Medicare Add on Payments for ambulance services which were appropriated as part of the Balanced Budget Act of 2018

Mr. Garrett added that the recommendations are all in alignment with the Vision 2050 document.

Mr. Robbins recessed the meeting at 1200 for lunch.

Mr. Robbins reconvened the meeting at 1:15pm and resumed committee reports.

## **NEMSAC Committee Reports Continued**

### *Equitable Patient Care Committee*

#### Reducing Social Inequities in EMS Through a National Out-of-Hospital Cardiac Arrest Registry

Dr. Bradley provided the committee report and highlighted the disparity in outcomes related to ethnicity and socioeconomic status that exists. The disparities impact children who live in predominantly African American communities. The committee recommended:

1. Establishing a national cardiac registry
2. Investigating the causes for inequities in out-of-hospital cardiac arrest outcomes
3. Continually developing, deploying and evaluating interventions with goals of reducing disparities in witnessed cardiac arrests of presumed cardiac etiology.

Mr. Gale asked what information is currently lacking from the NEMSIS database on the topic. Dr. Bradley explained that NEMSIS continues to improve, but room exists to refine and focus the variables that would go into a cardiac arrest registry. Additionally, the NEMSIS dataset does not include hospital outcomes. The registry would be managed with additional supervision beyond that which the NEMSIS database receives.

Mr. Washko asked why the committee is focusing on cardiac arrest when other inequities exist within EMS and whether it is necessary to create a separate database? He also asked if additional registries and datasets could be added to the current NEMSIS database and then aggregated? Dr. Bradley responded that cardiac arrest was selected because it is one of the easiest things to measure, and that perhaps as cardiac arrest improves, other disparities might improve. The committee recommendation is to start a Cardiac Arrest Registry. If NHTSA and FICEMS recommend that the registry should be part of NEMSIS, the committee would support that recommendation.

Dr. Krohmer shared that this is very consistent with an initiative going on at the National level, the National Cardiac Arrest Consortium. The Assistant Secretary for Health brought together partners to put together the CARES registry. It does not cover the entire county but is a well-established registry with a strong history of gathering valuable information. The community is working towards the formal acceptance of CARES as the in-hospital registry. We will need to

explore how to collect the pre-hospital data. Works has been ongoing to try and align NEMSIS data points with other national registries, such as stroke and trauma registries. Our goal may be to have the data elements necessary on the EMS side that can go into CARES or the other registries. However, the Council cannot recommend a specific proprietary product, such as CARES, only what we like what they accomplish.

#### *Preparedness and Education Committee*

##### *EMS Resource Allocation and Distribution during Disasters*

Ms. Lubogo noted that current preparedness efforts focus primarily on hospital-based preparedness and limited attention is given to the pre-hospital side. The advisory recommended that NHTSA consider:

1. Creating a research agenda to examine how EMS regional and national coordination during disasters could support preparedness efforts with a focus on current gaps in coordination and barriers to resource allocation
2. Assembling an ad hoc committee of private and public stakeholders including hospital administration, emergency managers, state and regional government, and EMS to establish best practices informed by current and new evidence
3. Working with private and public stakeholders to disseminate and implement best practices using proven methods including improvement science
4. Developing a collaborative, sustainable funding model that adapts to the changing needs of disaster preparedness and targets equipment, personnel, and training needs.

She added that more research is needed on how best to connect with FEMA and the agency's EMS resources.

Dr. Adelgais explained that much of the federal money is in a block grant formation, and what it may be spent on has been specified. The funds do not always get granted towards preparedness efforts. For example, FEMA money, in particular, is focused on 'after disaster' efforts.

Dr. Krohmer suggested the committee share this document and work aggressively with the Assistant Secretary for Preparedness and Response (ASPR). He also proposed having ASPR provide a detailed update at the next NEMSAC meeting. It would open dialogue for sharing identified gaps the Council is seeing in the field. Additionally, it may be useful to have FEMA come and present what is currently being done in this area as well, after which the Council could decide how to best frame the advisory moving forward.

##### Strategy for the Transition of Paramedics into a Profession with Formalized Education and Professional License to Practice

Ms. Lubogo explained that the goal of this advisory is to try and move the profession forward and consider the variety of ways to accomplish that task. The committee will be discussing the

recommendations in the afternoon session and work with partners on a proposal that optimally meets everyone's needs. They will be examining the Oregon and Kansas experiences, and looking to gain insights from Boston EMS and Bunker Hill. Identified barriers to formalized education include tuition fees and school loans.

Mr. Tobin would like to encourage NHTSA to conduct a study to ascertain whether patient outcomes are different with current EMS personnel compared to those with more formalized education.

Mr. Robbins reiterated that several individuals spoke during the public comment portion of the meeting to express opinions of their respective organizations. Both the International Association of Firefighters and the Emergency Nurses Association submitted written letters to the Council that will be circulated to the committee for consideration.

Mr. Garrett asked the committee to include all stakeholders in the discussion of this advisory. He noted that 70% of firefighters are volunteers and this would place additional burden on the volunteers. Currently, the number of volunteers has been declining and many challenges exist to obtaining reimbursement for EMS services. Additional education for paramedics is not going to change reimbursement in the short-term but is going to potentially exacerbate the workforce shortage. It will be challenging for paid paramedics earning \$7.50/hour to fund an associate's degree that may cost close to \$15,000. He is concerned that proposed changes will impact the most vulnerable groups that EMS currently serves: rural, underserved areas who currently receive all of their emergency services from volunteers.

Mr. Tobin added that the committee has revised their goal and are striving to determine what problems exist with the current paramedic situation, and how the committee can best work to elevate the career and EMS in paramedicine. Ultimately, the committee wants to identify gaps and how best to unite all sides to advance the profession.

Mr. O'Neal stated that he thinks that the requirement for paramedic education and certification should be left to the state associations rather than a federal government advisory council.

Dr. Fallat shared that she is fearful that some volunteers are not getting the education that they need. She doesn't necessarily feel that additional education should be an imperative and perhaps a tiered approach to the educational requirements for various EMS providers depending on needs.

Dr. Krohmer emphasized that NEMSAC does not have any regulatory authority, but makes consensus recommendations to NHTSA based on our combined expertise. The ultimate decision on this matter falls to the states, since they license health care providers.

Mr. Robbins recessed the general meeting at 3:19PM. Committees will meet until 4:30PM.

**Thursday, September 19, 2019**

At the discretion of the Council chair, Mr. Robbins called the meeting to order at 8:35AM. He invited members to continue with Committee Reports.

### **NEMSAC Committee Reports Continued**

#### *Adaptability and innovation Committee*

#### NEMSAC Support of CMMI Emergency Triage, Treat and Transport Model

Chief Gale provided the committee report and shared that the title was adjusted to reflect the intent of the advisory: that all delivery models be considered within the ET3. The advisory recommended that NHTSA consider:

1. Using the results of the ET3 project to evaluate how the desired programs could be implemented throughout the nation's various EMS service delivery models. NEMSAC is not recommending a change to the ET3 project scope, rather a consideration of the various EMS delivery models deployed throughout the US while collecting and analyzing data from the ET3 project
2. Upon completion of the project, consider how CMS could encourage participation in successful ET3 models by all EMS service delivery models in all types of urban, rural, and super rural areas and how potential Medicare rule and definition changes could allow and encourage this participation.

Dr. Krohmer explained that CMMI can only evaluate reimbursement information they are receiving under the current ET3 model. It will be difficult for them to look at the reimbursement impact of other models if that information is not currently being collected.

#### **Profession Safety Committee**

#### Mitigation of Violence Against EMS Professionals

Mr. Powers shared an updated version of the advisory in which the recommendations were adjusted based on yesterday's Council meeting discussions. The advisory recommended that NHTSA consider:

1. Coordinating with FICEMS on EMS to have a national summit to engage stakeholders and interested parties in discussing issues pertinent to workplace violence for EMS field personnel
2. Convening subcommittees to develop feasible recommendations for addressing data collection, education, and mitigation strategies informed by the summit proceedings
3. Developing a strategy for monitoring the subcommittee progress on implementing their recommendations and providing a progress report to NEMSAC on a semi-annual basis. The information should be made openly available

4. Utilizing a data collection system for violence reporting in conjunction with the Advisory titled, *NHTSA office of EMS as a Central Repository or all EMS Provider Safety and Wellness Data*.

#### Mental Health and Wellness for the EMS Providers and other Partners in Public Safety

Mr. Garrett shared that the committee made edits based on the Council's feedback and committee meeting yesterday. The advisory recommended that NHTSA consider:

1. Convening a summit on the subject of EMS provider mental health and wellness to address major issues and challenges in provision of provider mental health resources including suicide prevention
2. Developing an educational program to inform federal and nonfederal EMS stakeholders on the appropriateness of including mental health illness due to job-related performance/function a disability covered under worker's compensation for EMS providers
3. Utilizing a data collection system for mental health reporting in conjunction with the Advisory titled, *NHTSA office of EMS as a Central Repository or all EMS Provider Safety and Wellness Data*.

Mr. Robbins asked the committee to prepare the advisory for interim approval after lunch.

#### **EMS Sustainability and Efficiency Committee**

##### EMS System Financing Advisory 2019 Update

Mr. Emery provided the committee report and discussed edits to the advisory recommendations based on yesterday's Council feedback. The advisory recommended that, in coordination with FICEMS, NHTSA consider:

1. Supporting efforts of CMS to implement and ensure accurate cost data collection from ambulance services
2. Supporting efforts to update CMS regulations such that EMS is identified as a 'provider' type, enabling the establishment of conditions of participation in health and safety standards
3. Encourage CMS to account for EMS agency under-investments due to the lack of financial resources, such as expenditures in equipment, medications and personnel costs that agencies have not been able to implement due to chronic underpayment within the EMS system that deprive communities of necessary funding to provide state of the art care
4. Providing a dependable payment base for the operation of existing and investment in future EMS services needs allowing EMS agencies to focus on the provision of quality EMS services to their communities.

#### **Integration & Technology Committee**

##### Connected and Automated Vehicle Implications for Ambulances

Mr. Kaye and Ms. Gainor provided the committee update. The advisory committee recommended that NHTSA consider:

1. Facilitating the coordination and collaboration of resources between the FHWA, NHTSA and ITS JPO specific to EMS services; encourage the FTA and FMCSA to consider how systems being designed for use in vehicles in their modes respond to EMS and other incident management resources functioning on roads, highways, and roadside in an emergency capacity
2. Arranging one or more presentations to the Council by appropriate experts from FHWA, FMCSA, and FTA and maintaining contemporary awareness of existing and evolving technology to assess the impact on EMS
3. Establishing relationships with and identifying opportunities to participate in CAV-related initiatives being led by other modal administrations and the ITS JPO
4. Maintaining awareness about the rapidly evolving field of CAV and its inclusion of emergency response-specific needs.

Mr. Robbins asked that the committee prepare the advisory for interim approval after lunch. He also shared that the Council had received legal advice to turn the PECC endorsement into an advisory. He asked staff to circulate the updated version for discussion later in the morning.

#### **Trauma Request for Information: Improving Prehospital Trauma Care**

*Mary Fallat, MD, Trauma Surgeon*

A request for information on behalf of prehospital trauma care was published in the *Federal Registry*, Vol. 83, No. 82 on Friday, April 27, 2018. Dr. Adalgais reported that changes were made to the report based on feedback received from the RFI and the Council.

Mr. Robbins noted that this report will be discussed this afternoon and will be submitted as a final version. He recessed the meeting at 9:15AM for a 15 minute break.

Mr. Robbins reconvened the meeting at 9:30AM and noted that three items will be presented to the Council on which we would like to have action. Mr. Robbins requested comment on the advisory, *Request for Information: Improving Prehospital Trauma Care*. Mr. Robbins requested a motion to approve this document in its final form. Mr. Garrett moved to approve and Mr. Kaye seconded the motion. The motion was unanimously approved by the Council. The report will go to final.

Mr. Robbins asked for comment on the advisory titled, Pediatric Emergency Care Coordinator (PECC) for Emergency Medical Services. Dr. Krohmer requested that the committee work with staff to restate the advisory recommendations so they align with the Council's charge.

Mr. Robbins shared that Council members have talked and are supporting formation of a joint committee advisory to research the topic of pediatric restraint devices as presented by Ms. Gainor yesterday during the public comment period. The advisory will be a joint effort of the

following committees: Equitable Patient Care, Profession Safety, and Integration and Technology. Committee members will include, but are not limited to: Dr. Bradley, Mr. Powers, Mr. Kaye, Mr. McMichael, and Dr. Adalgais with Ms. Montera as advisory chair. The committee will begin to meet immediately to work on the issue and report back to the Council at the January 2020 meeting.

Mr. Robbins summarized that the Council will create a glossary reference document so that uniform terminology exists in advisory documents.

### **Discussion of NEMSAC Focus Areas for 2019-2020**

Mr. Robbins asked Council members to brainstorm topics and issues that committees may wish to work on. He opened the floor for discussion.

Several Council members noted that transporting behavioral health patient is a critical issue in terms of keeping EMS staff and patient's safe, including pediatrics. Since EMS personnel in the Tribal areas may be with patients for 3 to 4 hours during transport, it is a particularly relevant issue for them. Members suggested that this issue be a unique advisory since the topic contains patient and provider elements.

Mr. Kaye queried state offices on their thresholds for calling NHTSA to investigate an ambulance crash. State representatives said that they were aware of the service, but were unclear when to call NHTSA. He proposed that the Council write guidance for states on when a crash investigator should be called. Mr. Krohmer suggested the group add this to the ambulance crash recommendations. The Council will consider the topic in more detail and report back to the Council.

Ms. Bartram noted that emergency medical dispatchers (EMD) do not have standards for training or continuing education and proposed that the Council consider this as a critical issue. Dr. Adalgais added that this came up in the Trauma RFI and the preparedness and education committee is discussing how to make improvements to educational standards across the EMS field. Mr. Robbins tasked this topic to the Preparedness and Education committee and asked Ms. Bartram to participate.

Mr. Barrett suggested inviting the FAA to a Council meeting to discuss drone interference at emergency scenes. Dr. Krohmer and several other members concurred on the need to address potential issues. Mr. Bartram shared that some dispatchers send out drones to get photos and video of the scene and then transmit the information back to first responders before they reach the site. Mr. Robbins placed this topic under the Integration and Technology committee and asked Mr. Kaye to gather information on the topic to determine if an advisory is needed.

Mr. Tobin expressed concern about members of the public videoing emergency scenes. He proposed developing a best practices document for providers and provider agencies to advise

them on what is legal and what is illegal. Others concurred that guidance for public and private entities would be helpful as this is a First Amendment issue for all parties involved. Mr. Robbins said that the Council will obtain legal advice on what might be best approaches for a guidance.

He adjourned the meeting for a break at 10:40AM.

### **Public Comment**

Mr. Robbins reconvened the meeting at 11:00AM with the public comment session.

Mr. David Becker, Past Chair of the EMS section for the IFC expressed his gratitude for the opportunity over the past 3 days to provide input on the advisory titled, *Strategy for the Transition of Paramedics into a Profession with Formalized Education and Professional License to Practice*. He noted that the draft proposal has been postponed until the next Council meeting and wondered what the next steps for this proposal would be?

Mr. Robbins explained that committees meet via teleconference with a NHTSA staff member to decide how they are going to proceed. The updated advisory will be publicized on the NHTSA website several weeks prior to January 2020 Council meeting to allow the public to submit written comments. Any written feedback will be forwarded to the Council. If a revised advisory is ready, it will be presented and discussed at the Council meeting in January 2020 at which time another opportunity for public comment exists. The Council will not take any action until there is an additional opportunity for public comment in writing.

Mr. Robbins saw no further members of public wishing to provide comments.

### **Action on Proposed Advisories**

Mr. Robbins moved to pursue approval of presented advisories and stated that the Council will work through lunch and conclude the meeting prior to 4:00PM.

#### *Integration and Technology Committee*

##### NHTSA Office of Emergency Medical Services as the Central Repository for all EMS Provider Safety and Wellness Data

Mr. Kaye made a motion to bring the advisory to interim status. Mr. Bartram seconded the motion and the Council unanimously approved the motion. The advisory will be placed on the January 2020 Council meeting agenda for potential final approval.

##### Connected and Automated Vehicle Implications for Ambulances

Mr. Washko motioned to move the advisory to interim status. Chief Gale seconded the motion and the Council unanimously approved the motion.

*Adaptability & Innovation Committee*

Rural and Volunteer EMS Recruitment and Retention

Ms. Knight made a motion to bring the advisory forward to interim status. Mr. Emery seconded the motion and the Council unanimously approved the motion.

NEMSAC Support of CMMI Emergency Triage, Treat, and Transport (ET3) Model

Chief Gale motioned to bring the advisory to interim status. Mr. Garrett seconded the motion and the Council unanimously approved the motion.

*Profession Safety Committee*

Mitigation of Direct Violence Against EMS Professionals

Mr. Powers motioned to bring the advisory forward to interim status and Mr. O'Neal seconded the motion. The Council unanimously approved the motion.

Mental Health and Wellness for the EMS Provider and Their Partners in Public Safety

Mr. Garrett made a motion to bring the advisory forward to interim status. Dr. Bradley seconded and the Council unanimously approved the motion.

*EMS Sustainability and Efficiency Committee*

EMS System Financing Advisory 2019 Update

Mr. Garrett motioned to bring the advisory forward to interim status and Mr. O'Neal seconded the motion. The Council unanimously approved the motion.

*Preparedness and Education Committee*

Pediatric Emergency Care Coordinator (PECC) for Emergency Medical Services

Dr. Krohmer suggested that the Council have time to review the latest edits to the advisory before taking any action. Dr. Bradley moved to bring the advisory forward to interim status and Mr. Washko seconded the motion. The Council unanimously approved the motion.

Mr. Robbins motioned to allow NHTSA staff to make typographical and formatting edits to all advisories. Chief Gale seconded the motion which was unanimously approved by the Council.

Dr. Krohmer also noted the need to formalize the glossary document and add it to the advisory template.

**Review of Action Items and Wrap-Up**

Ms. Montero reiterated the dates for upcoming NEMSAC Council meetings:

- January 14-16, 2020
- April 14-16, 2020
- August 18-20, 2020, which will be the final meeting for current Council members.

Dr. Krohmer explained that the application process for individuals interested in serving on the next NEMSAC Council will be announced in the Federal Register. Applicants should apply, submit a CV, a letter of interest and letters of support.

Mr. Robbins motioned to adjourn the meeting at 11:40AM. Mr. Garrett seconded the motion and the Council unanimously voted to adjourn.