National Emergency Medical Services Advisory Council (NEMSAC)
Meeting Summary

May 1-2, 2024
Hyatt Place Georgetown
2121 M Street NW
Washington, DC 20037

Contents

Day 1: May 1, 2024

Call to Order and Opening Remarks

Brenden Hayden, NEMSAC Chairperson

Mr. Hayden called the meeting to order at 2:00 p.m. ET. He provided instructions for meeting participation. He noted that extensive public commentary has been offered on the NEMSAC Advisory on *Designating Graduate-Prepared Paramedics As Federally Recognized Practitioners*—possibly the most extensive public commentary in National Emergency Medical Services Advisory Council (NEMSAC) history.

Mr. Hayden explained that Congress established the Federal Interagency Committee on Emergency Medical Services (FICEMS) in 2005 with the purpose of coordinating efforts to support the EMS system. Members agencies have worked to improve and advance EMS and 911. In 2007, the U.S. Secretary of Transportation created NEMSAC to provide guidance to the Department of Transportation (DOT) and FICEMS. NEMSAC's charter requires that it comprise subject matter experts who represent key EMS communities. NEMSAC provides a mechanism for EMS communities to share their concerns with the Federal government. In 2012, Congress passed the Moving Ahead with Progress in the 21st Century Act, which called for the Secretary of Transportation to coordinate with the Secretaries of the Departments of Health and Human Services and Homeland Security to reestablish NEMSAC as a 25-member statutory advisory council with the purposes of advising and consulting with FICEMS regarding EMS issues and with the Secretary on EMS issues that affect the DOT.

NEMSAC advises but does not establish policy or pass laws. NEMSAC must operate in accordance with the Federal Advisory Committee Act (FACA) of 1972. FACA requires NEMSAC meetings to be public and announced through notices in *The Federal Register.* Meetings may not occur without the required announcement. Anyone can subscribe to *The Federal Register* and request notices only from specified agencies. The National Highway Traffic Safety Administration (NHTSA) also sends meeting notices through e-mail to EMS.gov subscribers.

NEMSAC meetings must include a public comment period. NEMSAC is not required to reach out to or engage with every member of the EMS community. Individual Council members are not allowed to speak on behalf of NEMSAC. NEMSAC has a government e-mail address to which members of the public can send comments (NHTSA.NEMSAC@dot.gov or Clary.Mole@dot.gov). Mr. Mole monitors comments and shares them with the full Council.

NEMSAC advice must complete two maturation phases prior to finalization: draft and interim. Advisories must remain in each phase until the next quarterly meeting to ensure that stakeholders have an opportunity to read and comment on them. NEMSAC has a new comment portal, which is where all advisories in draft or interim phases will reposited. Anyone can access the portal and read and comment on any advisory. The portal allows users to download and read the advisories and return to the website to enter comments or suggestions. All comments are submitted to NEMSAC's e-mail inbox, and the inbox is monitored by Mr. Mole.

Introductions of Members and Disclosure of Conflicts of Interest

Clary Mole, MS, NRP, NCEE, Emergency Medical Services Specialist, Office of EMS, National Highway Traffic Safety Administration (NHTSA); United States Department of Transportation (DOT)

Mr. Mole welcomed meeting participants and facilitated roll call on behalf of Gamunu Wijetunge, Director of the NHTSA Office of EMS. He invited NEMSAC members to introduce themselves, provide the town and state where they currently work, to and report any potential conflicts of interest. Participants were:

- Private EMS: Michael Thomas, Beckley, WV; potential conflict of interest (COI): Member of the Board of Directors of the American Ambulance Association (AAA)
- Fire-based EMS: Corey Condren, Concord, CA; no COI
- Hospital-based EMS: Paul Brennan, Lowell, MA; no COI
- Tribal EMS: Dr. Danita Koehler, Dry Creek, AK; no COI
- Local EMS Directors and Administrators: Lisa Basgall, Houston, TX; no COI
- Trauma Surgeons: Dr. Mark Gestring, Rochester, NY; no COI
- EMS Data Managers: Tom Arkins, Indianapolis, IN; no COI
- EMS Researchers: Dr. Jason McMullan, Cincinnati, OH; no COI
- Hospital Administrators: Brenden Hayden, Portsmouth, RI; no COI
- Public Health: Carol Jorgensen, Elm Creek, NE; no COI
- EMS Practitioners: David Fifer, Stanton, KY; no COI
- State Highway Safety: Bradley Estochen, Woodbury, MN; no COI
- Educators: Daniel Gerard, San Francisco, CA; no COI
- Quality Improvement: Mike Taigman, Oxnard, CA; potential COI: First Watch employee
- Volunteers: Wade Miles, Canton, GA; no COI
- State EMS Directors: Justin Romanello, Nashua, NH; no COI
- Medical Directors: Dr. Brandon Morshedi, Hot Springs, AR; no COI
- Emergency Physicians: Dr. Kendall McKenzie, Ridgeland, MS; no COI
- Pediatric Emergency Physicians: Dr. Sylvia Owusu-Ansah, Pittsburgh, PA; no COI
- PSAP Call-takers and Dispatchers: Casey Quintard, Sacramento, CA; no COI
- Emergency Nurses: Tabitha Vaughn, Indianapolis, IN; no COI
- Emergency Management: Dr. Frank Quintero, Dobbs Ferry, NY; no COI
- Consumers: Dr. Ayobami Ogunsola, Philadelphia, PA; no COI
- Air Medical: Eveline Byers, Spokane, WA; no COI

The Legislators sector representative, Suzanne Prentiss, of Lebanon, NH, was not present.

Approval of February 7-8, 2024 NEMSAC Meeting Minutes as an Official Record

Brenden Hayden, NEMSAC Chairperson

Mr. Hayden invited corrections and amendments to the February 7-8, 2024 meeting minutes. Participants did not suggest any corrections. The Council unanimously voted to approve the minutes.

Federal Interagency Committee on EMS (FICEMS) Update

Richard Patrick, FICEMS Chairperson

Mr. Hayden explained that FICEMS provides updates on relevant Federal partner activities to NEMSAC. Mr. Patrick said that FICEMS was established in 2005 to ensure coordination among Federal agencies that support local, regional, state, tribal, and territorial EMS and 911 systems, and to improve delivery of EMS throughout the Nation.

Department of Defense (DOD)

As of January 2024, Tracy Lattimore, who serves as the Executive Director for Health Readiness Policy and Oversight in the Office of the Assistant Secretary of Defense for Health Affairs within the Department of Defense (DOD), was appointed to serve on FICEMS. Ms. Lattimore succeeds Elizabeth Fudge, who retired at the end of June 2023. During the time after Ms. Fudge's retirement and prior to Ms. Lattimore's installation, Mark Gentliman served as Interim Director and Interim FICEMS DOD representative. At the March Executive meeting, Mr. Gentilman announced that he will retire from federal service. On behalf of FICEMS, Mr. Patrick congratulated and thanked Mr. Gentliman.

Department of Health and Human Services (HHS)

The Human Resources and Services Administration (HRSA) EMS for Children (EMSC) collaborated with the National Highway Traffic Safety Administration (NHTSA) Office of EMS to create a National Emergency Medical Services Information System-based (NEMSIS) Pediatric Readiness Dashboard to support national and state-level quality improvement efforts. The first dashboard will be available soon.

HRSA initiated the Pre-hospital Pediatric Readiness Project (PPRP) 4 years ago. The project aims to empower EMS agencies and clinicians to improve readiness through assessment, and to provide access to resources that advance pediatric readiness. The first comprehensive national assessment for PPRP launched May 1, 2024. Mr. Patrick urged participants to participate and use results to increase readiness at the system level. The deadline for assessment completion is July 31, 2024.

The Administration for Strategic Preparedness and Response (ASPR) has completed its responses to hurricanes, Maui wildfires, and a large-scale gun violence incident that occurred during 2023. The COVID-19 public health emergency drained emergency response infrastructure and health care provider resilience. The Emergency Medical System workforce needs additional mental health resources.

The Centers for Disease Control and Prevention (CDC) has reinitiated work with ASPR and the National Emerging Special Pathogens Training and Education Center (NETEC) to improve the national level EMS response during pandemics to include restoring capacity and capabilities previously built to respond to the Ebola virus. Projects include

development of clinical guidance for care of patients during transport and personal protective equipment (PPE) protocols.

The Centers for Medicare & Medicaid Services (CMS) continues to collaborate with other HHS operating divisions and the DHS Cybersecurity and Security Infrastructure Agency to address cybersecurity issues that are not exclusively related to EMS.

Indian Health Services (IHS) personnel continue with the process of conducting an internal review of a potential FICEMS representative. After a nominee is confirmed by the Director of IHS, the appointment will be announced during an upcoming FICEMS meeting.

Department of Homeland Security (DHS)

The DHS Office of Health Security (OHS) is continuing to work to address challenges in licensing portability by revising protocols and regularly convening the DHS EMS Training and Education Advisory Committee. The OHS is working with the DHS Office of the Inspector General (OIG) to create a program to allow non-healthcare professional staff of Immigration and Customs Enforcement (ICE) and Customs and Border Protection (CBP) to carry naloxone, as DHS continues its work toward build a framework to support an agency-based pre-hospital care reporting system.

The United States Fire Administration (USFA) has hired a fifth staff member to the EMS branch of the National Fire and EMS Programs division. USFA has become an ad hoc federal member of the Pre-hospital Blood Transfusion Initiative Coalition Steering Committee.

USFA convenes the annual Fire Prevention and Control Summit. Mr. Patrick co-chairs the team that organizes the summit with Chief Mary Cameli of the Mesa Fire and Medical Department in Mesa, Arizona. On April 30, 2024, ten working groups working on topics related to first responders met regarding the summit. EMS Branch Chief David Millstein and Chief Cameli presented a mid-year report. A final report is due in early September.

USFA, in collaboration with NHTSA, recently began a multi-year research cohort study on emergency responder safety. The study focuses on factors affecting responders' use of resources that affect their safety, especially their risk of being struck on roadways.

DHS Science and Technology Directorate is seeking emergency responders' input on the types of technology and equipment they are considering purchasing and using to inform what the System Assessment and Validation for Emergency Responders (SAVER) program should review next. Input will be accepted through May 24, 2024.

Occupational Safety and Health Administration (OSHA) issued proposed changes to rules for fire brigades. The agency has worked toward updating these rules since 2015. The proposed changes will be open for comment until June 21, 2024. Mr. Patrick encouraged participants to review and comment.

Department of Transportation (DOT)
NHTSA published a *Federal Register* notice, which published a request for information (RFI) that asked 22 questions; relevant responses will be used to inform to a technical expert panel that will be appointed to develop a strawman version of *EMS Education Agenda 2050*. The RFI was open until March 31, 2024 and received 99 responses, which are being and catalogued for use as the project continues to evolve.

The DOT *National Roadway Safety Strategy* (NRSS), published in 2022, discusses the goal of eliminating highway injuries and fatalities. The NRSS introduced the Safe Streets and Roads for All (SS4A) grants program, which funds regional, local, and Tribal initiatives. In February 2024, DOT announced SS4A funding opportunities and application deadlines. Planning grant applications are due 5:00 p.m. Eastern time May 16, 2024. Demonstration grant applications are due 5:00 p.m. Eastern time August 29, 2024. Implementation grant applications are due 5:00 p.m. Eastern time May 29, 2024.

States currently are updating NEMSIS v3.5; 45 states have completed the update. At the end of 2023, NEMSIS collected between 33 and 25 million records. The number of records collected in 2024 is expected to exceed this.

Federal Communications Committee (FCC)
The FCC is implementing initiatives to improve technical quality of the national 911 system's capabilities. In January 2024, FCC issued an order requiring wireless service providers to implement location-based routing for 911. This emerging technology routes most wireless 911 calls based on handset location rather than cellular tower location.

Steve McCoy, who represented State Office Directors on FICEMS, has announced his resignation after years of service. The Secretary of Transportation must appoint a new representative. NHTSA's Office of EMS sent a letter to the National Association of State EMS Officials (NASEMSO) to request three nominations by February 28, 2024. NASEMSO submitted nominations, which the selection panel has reviewed. NHTSA hopes to announce the new representative at the next public FICEMS meeting, which is scheduled for June 5, 2024.

Invitational Speaker Session – Part One

Just prior to today's meeting, the invitational speaker from National Emerging Special Pathogens Training and Education (NETEC) requested a presentation time earlier that published in the original agenda. The Council accommodated his request.

National Emerging Special Pathogens Training and Education Center (NETEC)
Alex Isakov, MD, MPH, FAEMS, EMS Lead, NETEC; Executive Director, Office of Critical Event Preparedness and Response, Emory University, Atlanta, GA

NETEC was founded to improve health system readiness to manage patients infected with special, highly infectious pathogens, but particularly in response to needs identified during the Ebola epidemic in West Africa 2013-2016. NETEC, co-led by Emory University (Atlanta, GA), University of Nebraska (Omaha, NE), and Bellevue Hospital Center (New York City, NY), provides technical consultation, readiness metrics, education, and resources for the health care community.

NETEC education and training resources are used to teach health care providers (HCP) standard, transmission-based precautions and how to implement hierarchy of controls for pathogens of concern, and how the hierarchies of controls are to be modified in consideration factors relevant to specific situations. Examples of situational considerations include ambulance supplies readily available for response (e.g. appropriate personal protective equipment) and relevant state and local policies and procedures. NETEC education resources teach HCP how to interface with hospitals that will receive patients and provides guidance for clinical care, waste management, and health monitoring.

Between 2014 and 2016, NETEC offered training to a small group of hospitals. Subsequently, ASPR and CDC provided funding to support the development of a network of Regional Emerging Special Pathogens Treatment Centers (RESPTCs). This network of thirteen (13) federally designated hospitals assess and maintain readiness to manage the care and treatment of patients who may be infected.

To effectively treat patients suspected of having high-consequence infectious diseases, hospitals require EMS partners that are able transport patients, implement seamless transfer procedures, communicate effectively with each other and the hospital, and ensure safety of all personnel. Network hospitals, EMS partners, and federal partners are part of a NETEC EMS Biosafety Transport Consortium, which meets quarterly to discuss challenges EMS providers face in responding to incidents potentially involving special pathogens, as well as best practices, and to develop strategies for improvement. NETEC defines four levels of readiness to manage patients with high-consequence infectious diseases. The RESPTCs that are the most prepared are designated as Level 1. In order to increase capacity, NETEC is now further developing criteria to define Levels 2-4.

A National Special Pathogens System (NSPS) of care requires EMS. The EMS role includes 911 communication centers, first emergency responders, and the EMS clinicians providing transport who are able to identify potential special pathogen involvement based on factors such as symptoms and travel history. There are significant distances between RESPTCs, which makes appropriate procedures for transportation particularly critical.

NETEC proposes an EMS framework that defines what all EMS personnel should be able to do, the role of specialty teams in addressing special pathogens, how specialty teams should be organized, and which federal resources can augment local and state capabilities. All EMS personnel should be able to 1) identify potential high-consequence infectious diseases, 2) isolate the patient to prevent their own and others' exposure to infection, and 3) appropriately inform so that the patient benefits from care and

transportation that is delivered safely. All EMS clinicians should be able to deliver a life-saving intervention if needed. Concern for high-consequence infectious disease should not paralyze HCPs and result in withholding care. NETEC proposes changing the national standard EMS education curriculum to address the unique requirements of providing care for patients with high-consequence infectious diseases.

Special transport teams need training in providing safe patient management and transportation for patients with high-consequence infectious diseases. For example, Phoenix Air Group operates a Gulfstream III, (a fixed-wing aircraft), which has been outfitted with an airborne biological containment system, and it is staffed by personnel specially trained to repatriate patients with high-consequence infectious diseases. Phoenix Air Group was federally funded to provided transportation for more than 44 patients during the Ebola virus outbreak between 2013 and 2016, it will continue to provide these critical support services through a 10-year contract with the U.S. State Department. Phoenix Air Group has one airplane capable of transporting one patient at a time, and the State Department has a containerized biological containment system unit that can be loaded into a 747-cargo jet, but this system is not practical for transporting patients within the continental United States. ASPR is working to develop a similar system that would be practical for this purpose.

The NETEC EMS/Patient Transport Work Group and the Biosafety Transport Consortium works to develop and offer EMS-specific training and to develop template policies and procedures designed to improve EMS system readiness. Such training includes a course on EMS Biosafety Transport for Operators and another for Biosafety Transport Technicians. The didactic portion of the operators' course is available online. NETEC collaborated with ASPR Technical Resources, Assistance Center, and Information Exchange (TRACIE) to develop, publish, and maintain the *EMS Infectious Disease Playbook*, which guidance for responding to all pathogens, but it also describes specific actions to be taken when in response to highly infectious pathogens such as viral hemorrhagic fever and special respiratory pathogens. Dr. Isakov pointed out that resources often are developed immediately following an epidemic, then not updated thereafter. He praised APSR TRACIE for continuously updating the *Playbook*.

NETEC recently published *EMS Procedural Guidelines for Special Pathogens,* which NHTSA OEMS and USFA have disseminated. Every EMS agency should be aware of and implement model guidelines for tasks such as cleaning biohazard spills, assessing personal protective equipment breaches, and managing Category A waste. NETEC maintains blogs about current special pathogens threats, such as a recent post about updates to the Department of Transportation's guidance for managing waste associated with caring for patients with a clade 1, clade 2, or clade 2B Mpox infection.

NETEC and its partners have developed a Special Pathogen Operational Readiness Self-Assessment (SPORSA) for EMS agencies. The tool helps assess all aspects and phases of EMS patient care, from first response to specialty team engagement and transportation. Agencies that participate in the readiness self-assessment receive feedback and links to relevant resources to address their specific needs for improvement. NETEC offers

consulting services from EMS subject matter experts who have real-world experience transporting patients with high-consequence infectious diseases.

NETEC is a resource for developing readiness metrics, providing technical consultation, and developing, maintaining, and disseminating education and training activities and resources. NETEC seeks to collaborate with partners to develop a framework for safe patient management and transport to support a national special pathogen system of care. NETEC welcomes input. Mr. Gerard expressed admiration for NETEC's work.

Standing Subcommittee Advisory Reports and Updates

Brenden Hayden, NEMSAC Chairperson Brenden Hayden, Chair, NEMSAC

Subcommittee chairs provided updates on their respective subcommittee activities conducted since the February 2024 NEMSAC meeting.

Adaptability and Innovation

David Fifer, Subcommittee Chair

Mr. Fifer said the subcommittee will be requesting that its advisory regarding the graduate-prepared paramedics be approved as final during meeting day 2 of this convening of NEMSAC. The subcommittee is continues its research on body-worn cameras in EMS.

Equitable Patient Care

Jason McMullan, Subcommittee Chair

Dr. Koehler is leading the development of the advisory entitled, *Equitable Access to EMS Based on Population Density*, which is in the research phase. An advisory on mitigating the medication supply and device shortage is also in the research phase; it should also be noted that within the past 2 days, the National Association of EMS Physicians (NAEMSP) launched a member survey that will solicit information relevant to the advisory. The latter advisory is likely to be in the draft phase by August 2024. A separate advisory on establishing improved and equitable access to pre-hospital blood transfusion for EMS agencies is in the research phase. A letter to FICEMS requesting support for the Pre-hospital Pediatric Readiness Project was drafted in February and the subcommittee plans to motion to finalize it during meeting day 2 of this convening of NEMSAC.

Preparedness and Education

Lisa Basgall, Subcommittee Chair

The subcommittee is conducting background research for its advisory on *EMS Response to Active Threats: A Multifaceted Approach to Preparedness and Coordination*. The subcommittee also reported that it would make a motion to finalize the advisory entitled, *Large-scale events: EMS Planning and Coordination,* on meeting day 2 of this convening of NEMSAC. The subcommittee is also developing a letter to FICEMS on exertional heat emergencies and EMS response and plans to motion that it be accepted as a draft letter on meeting day 2 of this convening of NEMSAC.

Professional Safety
Carol Jorgensen, Subcommittee Chair

The advisory entitled, *Crash Scene Safety,* was expected to progress from the interim to final phase on Day 2. The advisory makes multiple recommendations for preventing secondary crashes to protect emergency responders and others at crash scenes.

On meeting day 1 of this convening of NEMSAC, the subcommittee plans to propose the advisory entitled, *Quantifying Workplace Violence against EMS Practitioners,* be retitled, *Quantifying Violence Against EMS Clinicians.* This advisory is in the research phase. The subcommittee is also developing a draft letter of recommendations to FICEMS in support for increased understanding of the extent of workplace violence against EMS clinicians and how to address it. Because of the time required to develop an advisory and the urgency of the problem, the subcommittee developed a said letter to FICEMS for NEMSAC's consideration. The advisory entitled, *Establishment of an EMS Injury and Violence Surveillance System,* continues to be in the research phase.

Sustainability and Efficiency
Paul Brennan, Subcommittee Chair

The *Strategies for Mobile Integrated Health Care and Community Paramedicine Funding and Reimbursement* advisory, which is in the research phase, will include discussion of telemedicine and treatment in place. The advisory on *Establishing Pre-hospital Physician Practice Reimbursement Models for Improved Patient Care and EMS Physician Oversight also* continues to be in the research phase.

Integration and Technology
Thomas Arkins, Subcommittee Chair

Mr. Arkins reported that the subcommittee would motion for the advisory entitled, *EMS Data Manager Career Pathways,* to be finalized on meeting day 2 of this convening of NEMSAC. The *Bidirectional Data Sharing between EMS and Hospitals* advisory continues to be in the research phase. The *Identification and Modification of Biased, Inappropriate, Inflammatory, or Derogatory (BIID) Language in EMS Documentation to Reduce Biases in Clinical Care* advisory also is in the research stage. The subcommittee plans to revise this advisory to place more emphasis on educational documentation standards. The *Best Practices for Use of Language Translation Tools in Pre-hospital Settings* is in the research phase, but the subcommittee plans to motion it be accepted as draft on meeting day 2 of this convening of NEMSAC.. Little information has been found to inform the *Universal ID Bands for Improved Prehospital Patient Tracking & Data* advisory; the subcommittee is considering how to proceed.

Ad Hoc Subcommittee on Ambulance Crashes Reports and Updates

Mark Gestring, Subcommittee Chair

The subcommittee intends to motion that the advisory entitled, *Development of a Comprehensive Ambulance Crash Data Collection Platform to Better Understand Current Crashes and Guide Future Preventive Strategies,* be finalized on meeting day 2 of this convening of NEMSAC.

New Advisory Proposals

Brenden Hayden, NEMSAC Chairperson

Mr. Hayden announced that no new advisories would be proposed. He explained that members who propose new advisories must identify the intended federal audience, goals for recommendations to be developed, and whether the proposed recommendations are within the intended federal audience's statutory authority, whether there is existing relevant federal guidance, whether there is need for additional guidance, and whether the proposed advisory will contribute to addressing that need.

Invitational Speaker Session – Part Two

Aerospace Emergency Medicine

Susan Northrup, MD, MPH, Federal Air Surgeon, Office of Aerospace Medicine, Federal Aviation Administration (FAA), U.S. Department of Transportation

The air travel population has changed over the past 20 years from being mostly business to mostly leisure travelers as a result of efforts to contain business costs, the ability to teleconference, and to lower costs that make vacation travel more affordable. There are more very young and elderly air travelers, increasing the range of potential medical emergencies.

Internationally, there is a medical event in the air for every 1,000 departures and one fatality per million passengers. According to a 1998 Aerospace Medical Association survey, the diagnoses most commonly associated with aerospace emergencies are cardiac (n=191), syncope (n=111), seizure (n=61), asthma (n=42), and diabetes (hypoglycemia or hyperglycemia, n=31). Incidence data collected from operations reports indicate that the most prevalent conditions are cardiac (29.4%, with 3.7% of those related to blood pressure), loss of consciousness/syncope (14.1%), musculoskeletal (13.3%), seizure (7.5%), respiratory (7.5%), and gastrointestinal (7.0%). Cardiac events ranged from arrythmia to heart attacks and hypertensive crisis. Tripping and falling during turbulence is a common cause of musculoskeletal injuries. Gastrointestinal problems are the main reason the pilot or crew request medical care, followed by cardiac problems. Less commonly reported issues are obstetric/gynecological (OB/gyn; 3.3%), stroke (3.3%), psychiatric (2.9%), diabetes (2.5%), allergy (2.5%), hazmat (1.6%), headache (1.6%), rash (1.2%), ear, eyes, nose, or throat (1.2%), overmedication (1.2%), burn (0.4%), bite

(0.4%), and needle stick (0.4%). Going into labor is the most common OB/gyn issue. Hazmat issues typically result from people putting hazardous materials in their luggage. Animal bites sometimes occur when passengers remove their pets from carriers, although young children and adults are responsible for some bite injuries. Airplanes offer safe containers for needles, some people put them in the pockets behind seats, creating a needle stick risk. Ms. Basgall asked how prevalent opiate-related emergencies are in air travel. Dr. Northrup said the FAA currently is studying this question. Several airlines stock medication for opiate overdose on airplanes.

Jurisdiction over fatalities in airplanes varies by State. International jurisdiction is determined by the nationality of the airline. Reporting requirements vary by country. Some airlines do not accept do not resuscitate (DNR) orders.

Since the September 11, 2001 attacks on airlines, air crews have been required to lock the cabin door as soon as a medical issue is declared. Therefore, medical and first aid kits are not stored in the cockpit, and storage locations vary. Crews sometimes discourage care providers from using more advanced kits. Medical responders should be prepared to insist on access if necessary. Oxygen kits are either a single port that lasts as long as 77 minutes or dual port that lasts as long as 154 minutes. Medical responders that volunteer to provide care are required to complete paperwork.

Supplies routinely kept in the main galley include non-aspirin pain relievers, antacid tablets, gloves, alcohol swabs, and adhesive bandages. First aid kits include adhesive tape, a pocket mask, ammonia inhalants, wire splints, scissors, bandages, antiseptic wipes, and gloves. Since April 2005, airplanes have been required to carry an enhanced emergency medical kit. The captain has authority to decide whether to release the kit for use. Responders are asked to display their license, certification, or professional identification. If the responder does not have any of these, the crew will ask questions to verify qualifications. Kit contents are specified in Air Carrier Certification Code of Federal Regulations Title 14 Part 121 Appendix A, and some items currently required are no longer accessible. The reauthorization bill in progress will allow updates to these contents as new medical evidence emerges. Flights cannot be dispatched without a sealed enhanced emergency medical kit onboard, so most airplanes stock two kits. A placard on the front lists contents. Kits include guidance for use.

Enhanced emergency medical kits include syringes prefilled with atropine (0.1 mg/10ml; n=2), diphenhydramine (50mg/1ml; n=2), dextrose (50%/50 ml; n=1); epinephrine (1:1,000, 1 mg/1ml; n=2), epinephrine (1:10,000, 0.1mg/ml; n=2), epinephrine 0.3 mg auto-injector; n=1), and lidocaine (20 mg/cc, 5 cc; n=2). Some airlines use a different type of auto-injectable epinephrine. Capsules and tablets include aspirin, acetaminophen, diphenhydramine HCL, and nitroglycerine. Enhanced emergency medical kits include an albuterol inhaler. Flight attendants can ask whether passengers have medication requested by the responder to address a medical issue. Enhanced kits also include non-latex gloves,

needles, syringes, saline solution, an intravenous (IV) set with a 2Y connector and catheters, as well as alcohol prep pads, an adhesive tape roll, trauma shears, tourniquet, sharps container, stethoscope, a blood pressure cuff, and airways.

Airplanes carry a medical accessory pack, which includes a biohazard clean-up kit and a personal protection kit, with gowns and gloves as well as a glucometer. Airplanes also carry an automated external defibrillator with an extra battery. They carry a universal precautions kit with fluid solidifiers, scoops, and scrapers. Flight attendants know where medical kits are located. Airlines must approve before medical oxygen can be used during the flight. Oxygen concentrators are acceptable, as are vented IV bags that do not interfere with equipment or require assistance from the crew. Bags must be vented because air expands with altitude.

Flight attendants may be trained, but not certified in cardiopulmonary resuscitation. Crews may contact medical support on the ground before paging passengers. Approximately 85% of domestic flights have a medical provider onboard. The Aviation Medical Assistance Act protects medical responders from liability, provided they work within the limits of their credentials and skills.

The Air Carrier Access Act requires airlines to provide transportation to people with disabilities. Carriers cannot refuse to transport solely due to appearance or involuntary behavior that may offend or inconvenience the crew or other passengers. Airlines can require a medical certificate. Airlines can refuse to board passengers who are intoxicated, on stretchers or incubators, carrying an infection that could be transmitted during the flight, potentially dangerous due to unsound mind, disorderly, barefoot or unclothed from the waist up, or malodorous but not disabled.

Researchers are studying the feasibility of safely fastening wheelchairs to airplane floors. People with disabilities requiring assistance to exit quickly during an emergency may not be seated in exit rows. Airlines avoid seating passengers who have these conditions in aisle seats. Flight attendants are not required to assist passengers with disabilities with eating beyond cutting food. Flight attendants can stow and retrieve carry-on items and assist with onboard wheelchairs. Flight attendants will not administer medication, assist with voiding, or help operate medical devices.

Discussion

Mr. Hayden asked how many Council members had assisted with a medical emergency on an aircraft. Many members indicated that they had. Mr. Hayden said this confirmed the relevance of Dr. Northrup's presentation. He said all EMS professionals should know what is in medical kits on airplanes. He reported that he had found it difficult to identify contents when he opened an onboard medical kit.

Dr. Gestring asked whether airlines restrict travel past a specified length of pregnancy. Dr. Northrup said pregnancy is a relative contraindication and that pressure changes in flight can cause issues for pregnant people. Dr. Gestring noted that some agencies provide ground medical support for airlines. He asked Dr. Northrup to describe this support. Dr. Northrup said Med-Air is the major provider in the U.S. Med-Air is also a major emergency medical kit provider. The University of Pittsburgh Medical Center has provided real-time medical information for some airlines.

Dr. Owusu-Ansah asked whether researchers are collecting current data on medical incidents in airplanes. Dr. Northrup said incidents are reported to the Transportation Operations Center. Dr. Owusu-Ansah said the American Academy of Pediatrics is collaborating with FAA to ensure medical kits include items to support preparedness for pediatric emergencies. She asked for the status of these efforts. Dr. Northrup said reauthorization of the Aircraft Certification Code is necessary to implement recommendations for updating contents of medical kits.

Chief Romanello asked what can be expected as the minimum contents of medical kits on international flights. Dr. Northrup said airline nationality determines jurisdiction. The country with jurisdiction sets requirements for medical emergency preparedness.

EMS Delivered by Drone

Chris Lester, Interim Division Chief, Field Operations, Special Projects-Aerial Recon-Transport-Aid-Navigation (SPARTAN), Unmanned Aerial System (UAS) Program Manager, Austin/Travis County EMS (ATCEMS)

Jason Burnside, Program Manager, Robotics Emergency Deployment (RED) Team, Austin Fire Department

ATCEMS and Austin Fire Department work closely together to serve a community of 1.4 million people in a 1,039 square mile area. Austin has the tenth largest city population, in the U.S. In 2023, ATCEMS answered 158,690 calls for EMS service, and Austin Fire Department answered 109,280 emergency calls.

The Austin Fire Department has approximately 1,200 sworn personnel, 8 battalions, and 53 fire stations. The Department has a Special Operations Division and a Wildland Division. UAS is part of the Special Operations Division and has a staff that includes 25 pilots. The Department has 43 UAS aircraft.

ATCEMS has 689 sworn employees, 110 of whom are civilians. The agency has 48 ambulances. Seven district commanders manage ATCEMS. The agency has a full-time Special Events Division, Emergency Management Division, community health paramedics, and a Collaborative Care Communications Center. The UAS team includes 22 pilots and 30 aircraft.

Public safety and law enforcement agencies in Central Texas collaborate with the SPARTAN and RED teams to serve their communities. Staff at all agencies must complete cross-agency training to ensure seamless response. Agencies have communications procedures that support coordinated emergency response and resource sharing. Teams coordinate to determine optimal use of drones for emergency services. SPARTAN auto-dispatches for search and rescue, mass casualty, and active shooter emergencies. The agency also will dispatch drones for other emergencies, such as fire missions, on request. The RED Team places thermal aircraft on every chief vehicle in the city. Nine operational aircraft can be deployed across the city. RED team auto-dispatches for all fires with at least two alarms, and all technical rescues, such as water and hazmat rescues, as well as active attacks.

Drones can transmit video of emergencies to command posts and anyone with the right log-in credentials. People on the scene can view other parts of the scene. Thermal imagery facilitates assessing how hot fires are and locating people. Drone imagery generates maps that define where teams should work. It also prevents conflicting placements. In 2023 the SPARTAN and RED teams logged 772 total flight hours.

Community health paramedics use drones to locate and assign addresses to camps in the woods made by people experiencing homelessness. Drones allow overwatch of camps without having to be in the woods, which may have dangers such as wild dogs. Drones allow paramedics to provide some types of assistance without having to directly interact with a person who does not want assistance. Staff providing overwatch can share drone video with supervisors.

The teams are exploring the possibility of using drones as first responders. Drones often can deliver Narcan faster than ambulances, possibly while the caller is on the phone with an emergency dispatcher who can provide instructions for administering the medication. Drones also can deliver other medications, supplies, and equipment in minimal time. Drones are better able to travel during icy conditions than ambulances, including 4-wheel drive vehicles. The team once used a drone to deliver insulin when vehicles could not travel icy roads. The Fire Department of New York has used drones for beach rescues. SPARTAN and RED are working with swift water swimmers and boat operators to integrate drones into their work. Drones offer aerial views that can help to locate patients. Drones can bring inflatable flotation devices to emergency scenes while rescue teams or lifeguards are in transit.

The teams are exploring possible uses of Electrical Vertical Take-off and Landing (eVTOL) vehicles, which allows the team to bypassing traffic to get people and tools to emergency scenes quickly. Johnny Doo, who leads eVTOL research for the National Air and Space Administration's (NASA), has collaborated with Mr. Lester to publish two articles on how to use drone technology to carry people. Twelve U.S. companies manufacture drones with this capability. These drones have less lift capacity and duration than helicopters, but they support moving people quickly.

Organizations should have aircraft with diverse capabilities to address different needs. Systems should be interoperable and allow sharing airspace safely and effectively. Systems should support sharing drone video feeds with other agencies, regardless of the types of drones they fly, and be able to stream information to any viewer. Systems must be reliable. Thermal cameras are essential. Equipment should be weather-resistant, have a flight time of at least 30-60 minutes, low light capability, and high-powered optimal zoom, while being cost-efficient.

China currently makes some of the best quality drones. American drone manufacturers are struggling to compete. Products are out-of-date and costly. American companies need support to be able to obtain better technology.

Discussion
Ms. Basgall asked whether drone footage becomes part of the EMS record. Mr. Burnside said not all drone footage is recorded. Search and rescue footage is recorded and stored as part of the EMS record.

Chief Romanello asked whether any members of the public have reacted negatively to the teams' collaborating with police. Chief Lester said this was not the case. The team is transparent, shares data on request, answers questions from the public, and invites media representatives to observe its work.

Mr. Taigman asked what research the teams are planning or conducting. Chief Lester said their research has consisted of collaborating with Johnny Doo to develop the articles mentioned during the presentation.

Dr. McKenzie asked the presenters to discuss line of sight limitations and efforts to overcome them. Chief Lester said the teams launch as high as possible and try to have team members working on the ground. The FAA can issue certificates of waiver or authorization for operation beyond visual line of sight. The team can assign enough flight crews in a geographic region to obtain adequate line of sight.

Bringing Space Medicine Down to Earth for EMS Benefits

Kris Lehnhardt, MD, FRCPC, FACEP, FAsMA, National Aeronautics and Space Administration (NASA), Associate Professor, Department of Emergency Medicine, and Center for Space Medicine, Baylor College of Medicine

The International Space Station has been in continuous operation for 23 years. Medical services include screening protocols and health maintenance activities, and protocols and equipment to address medical emergencies and minor medical events. NASA aims to send humans to Mars. While the Space Station is 250 miles above Earth (closer than Houston is to Dallas) Mars is thousands of times further. Space station missions last 6 months to 1 year. The Space Station communicates with personnel on Earth in real time, has a strong consumables resupply system, and can return samples to Earth. Space Station personnel can return to Earth as soon as 6 hours.

A Mars mission would last 2-3 years. There would not be resupply of consumables. Real-time communications, sample returns, and evacuations would not be possible. Mars missions will require expanded onboard medical care and medical operations independent of Earth. NASA's efforts to build the medical autonomy necessary for a successful mission to Mars include considering how to increase capability for in-situ analysis, enhance medical procedure support, develop advanced computing tools that assist clinical decision-making, and efficient use of resources to minimize need for resupply.

The white blood cell analyzer is an example of in-situ analysis capacity. NASA modified a commercial, off-the-shelf device for use in a microgravity environment, then tested it in the Space Station. White blood cell tests support diagnosis of infection and acute radiation exposure. This type of technology could be deployed in a remote or disaster environment. Point of care blood analysis testing could accelerate initiation of antibiotic therapy for conditions such as sepsis.

NASA and the EMS community can communicate their needs to technology developers so that they develop technology based on use cases. NASA worked with a company to develop the rHEALTH ONE integrated point of care blood analyzer, which is designed to address NASA's needs in a spaceflight environment. NASA tested the device at the Space Station and confirmed that it works. It may also be appropriate for use in remote or disaster locations.

NASA explored using procedure guidance tools to support astronauts in performing complex medical procedures with little to no training. NASA developed a software tool that supports self-paced learning with text, video, or images, depending on learning style. Astronauts used the tool to learn to generate ultrasound images with quality adequate to support diagnosis. Training began with a kidney and bladder ultrasound module because of the prevalence of urinary retention and kidney stones during spaceflight. A previously untrained ultrasound technician was able to produce diagnostic-quality images within an hour.

Astronauts need tools to support good clinical decision-making. The first step toward achieving this is to store data in one place. NASA is developing integrated data architecture to store comprehensive health and performance data on crew members in one place, and to display the information to the crew so that they can use it to support decisions. The next step is to develop this system so that it works with tools that analyze data and generate reports that inform clinical decision-making without support from Earth.

Astronauts must use onboard resources very efficiently. This also applies to disaster and remote locations as well as pre-hospital emergency situations. NASA developed a device that sterilizes and purifies potable water and adds electrolytes needed to produce intravenous fluid consistent with Food and Drug Administration (FDA) guidelines. NASA aims to integrate this intravenous fluid generation device into all vehicles and connect it to life support systems. This avoids transporting heavy, voluminous IV fluids that could expire before use. NASA would like to reduce the size of the device to no

larger than a lunchbox. This device could be used to serve disaster or resource-poor areas and may be available in ambulances and hospitals in the future.

Discussion
Mr. Taigman asked how NASA is exploring the use of artificial intelligence (AI) for diagnosis and treatment support. Dr. Lehnhardt said there are concerns about publicly available AI tools, such as hallucinations and data sources. NASA is conducting small pilot projects to explore possibilities. NASA is explaining its needs to vendors, who develop products based on use cases.

Dr. Gestring pointed out that sailors used to be required to have their appendices removed prior to a submarine voyage. He asked whether astronauts might be required to have preventive surgery and thorough screening for early signs of cancer before participating in long missions. Dr. Lehnhardt said preventive surgery is associated with some increased risks. Astronauts are thoroughly screened at time of recruitment. Data collected during recruitment could be stored and used to inform clinical decision-making.

Mr. Hayden asked for a description of how telemetry modeling of astronauts is used in the International Space Station. Dr. Lehnhardt said astronauts are most closely monitored when they are wearing spacesuits on space walks.

Mr. Fifer asked whether telehealth could support emergency service providers, such as ambulance staff, in providing medical care. Dr. Lehnhardt said this is a viable option for the future.

Mr. Arkins asked how NASA distinguishes rescue from recovery. NASA says these circumstances have not arisen at the Space Station. NASA is working to predict how often these events may occur as humans explore Mars and further. It will modify its medical systems to minimize risk. Mars missions will necessitate the development of protocols for dying in space.

Chief Romanello asked whether there is a maximum expectation for astronauts' capability to perform medical procedures. Dr. Lehnhardt said astronauts are likely to be uncomfortable performing difficult invasive procedures. NASA will address this through pre-flight training and experience in hospitals. Astronauts may be required to perform procedures that make them uncomfortable in order to meet other crew members' needs. Chief Romanello asked whether liability is an issue for astronauts who provide medical care for each other. Dr. Lehnhardt said liability is not an issue during spaceflight, since only NASA has jurisdiction in space.

Public Comment
Brenden Hayden, NEMSAC Chairperson

No public comment was offered.

Review of Action Items and Wrap Up

Brenden Hayden, NEMSAC Chairperson

Mr. Hayden thanked all meeting participants for their work. He adjourned the meeting at 5:11 p.m. Eastern time.

Day 2: May 2, 2024

Reconvene and Instructions

Brenden Hayden, NEMSAC Chairperson

Mr. Hayden called the meeting to order at 1:00 p.m. Eastern time, welcomed participants, and reviewed rules for participation. Mr. Mole confirmed that a quorum was present.

National Roadway Safety Strategy: Post-crash Care Update

Gam Wijetunge, NRP, Director of the Office of EMS, NEMSAC Designated Federal Officer, NHTSA, Department of Transportation

The Department of Transportation (DOT) aims to eliminate roadway deaths and injuries in the United States. Post-crash care is an integral part of the DOT's strategy for achieving this goal. The Safe System Approach includes five objectives: safer people, safer vehicles, safer speeds, safer roads, and post-crash care. Post-crash care provides expedient access to emergency medical care. The National Roadway Safety Strategy (NRSS) includes three main goals: improve EMS delivery and utilization and support for NEMSIS, enhance traffic incident management training and technology to ensure safety of EMS personnel and motorists at the crash scene, and improve EMS delivery across the nation.

NHTSA's preliminary estimate is that more than 41,000 people died in car crashes in the U.S. during 2023. This is a decrease from 2021, but still excessive. Approximately 40% of people who die in crashes are alive when EMS arrives on the scene, then die within 30 days.
In 2021, EMS responded to 8,747 crashes in which a vehicle occupant was completely or partially ejected. A total of 48,517 incidents involved vehicle extrication. EMS responded to 169,462 seriously injured crash patients, who likely would have died without intervention.

Reducing mortality requires utilizing emergency medical dispatch, timely care at the scene, transport to a trauma center, and performance measurement for the entire system of care.
Mr. Wijetunge thanked the Council for its letter to NHTSA on priorities for improving post-crash care. NHTSA is working to implement these recommendations.

NHTSA is using funds from the Bi-partisan Infrastructure Law (BIL) to support the Section 402 Highway Safety Program, Section 405 National Priority Safety Program, Safe Streets and Roads for All (SS4A) Grant Program, and the Strengthening Mobility and Revolutionizing Transportation (SMART) Grants Program. The Section 402 Highway Safety Program has funded grants to State Highway Safety Offices (SHSO) for more than 50 years. BIL increased funding by approximately 50%. The program recently awarded $1.7 million to the Los Angeles

County EMS Agency to improve training for responding to trauma, and to improve data linkage across EMS agencies, emergency departments, and trauma centers.

The Section 405(h): Preventing Roadside Deaths Program awards approximately $1 million to each awardee. The State of Maine is using funds to use vehicle-to-everything (V2X) technology to provide digital alerting transponders and high-speed internet in all ambulances and other EMS vehicles.

SS4A is a 5-year, $5 billion program to prevent deaths and serious injuries on roadways. The SS4A program funds regional, local, and tribal initiatives through grants. The program awarded $201,500 to the Upper Pine River Fire Protection District in Colorado to develop a comprehensive safety action plan for post-crash care. SS4A awarded $2.4 million to the Town of Colonie, NY to pilot an emergency transponder system to alert drivers of emergency response to crashes and to test a platform to support interfacing with specialty care registries.

The SMART program awards grants for public sector agencies to conduct demonstration projects on advanced smart community technologies that enhance transportation efficiency and safety. SMART awarded the Southern Alleghenies Planning and Development Commission in Pennsylvania $2 million for a pilot project designed to deliver naloxone and automated external defibrillators (AEDs) directly to 911 call sites by drone.

Mr. Wijetunge encouraged participants to visit EMS.gov and 911.gov to learn about programs and funding opportunities. He said OEMS staff are available to answer questions.

Discussion
Mr. Thomas asked whether private for-profit agencies were eligible for any of the funding opportunities Mr. Wijetunge had described. Mr. Wijetunge confirmed that private for-profit agencies were not eligible to be direct grantees but could partner with eligible local government agencies.

Invitational Speaker Session

Overview of NEMSIS Data Elements

Jeremiah Kinsman, MPH, EMT, EMS Specialist, Office of EMS, NHTSA, U.S. Department of Transportation
Chris Hoffman, NEMSIS Technical Assistance Center (NEMTAC)

During the 1990s the NASEMSO asked NHTSA and CDC to help develop an electronic EMS data information system. The National EMS Information System (NEMSIS) was founded with the aim of creating a national standardized system for collecting, validating, storing, and sharing EMS data in a timely matter. NHTSA wanted the system to support benchmarking and analysis, which would inform development of protocols and evidence-based guidelines.

The NEMSIS data standard includes 640 elements, and 155 of those elements are collected at the national level. NHTSA requires collecting some data elements and recommends collecting others. NEMSIS Web Services allows electronic Patient Care Record (ePCR) vendors to submit data to the State and allows States to submit data to the national database. The Web Services resource also allows data sharing between ePCR products and devices. The NEMSIS Schematron validates NEMSIS data and allows state agencies to share data with hospitals and health systems. All 50 States, DC, and three of the Territories collect and submit version 3 NEMSIS data. The current version is 3.5, and all but five or six States use this version. More than 54 million records were collected in 2023. About 87% of emergency incidents reported nationally will be available in NEMSIS within 2 days. NEMSIS data seamlessly integrate with medical devices and 911 call centers. NEMSIS allows rapid data transmission from the point of care to the State and National databases.

Data dictionaries are available on the NEMSIS website. Some data elements are related to EMS response during emergency events. Some elements are demographic. States can customize and add data elements. Submitted records must include required elements to be accepted into the national database.

NEMSIS offers dashboards and public reports. The Data Cube offers video tutorials on using NEMSIS. Mr. Kinsman demonstrated how to request tailored data reports. NEMSIS supports crosstabs and adding percentages. Data can be downloaded to Excel or pdf files.

NEMSIS offers a self-directed State Data Manager training course through the Moodle learning management system; vendors and researchers also have taken the course. Users can sign up for NEMSIS events notifications . The course provides an opportunity for learners to connect and learn from each other. The course comprises 16 videos that take a total of 3 ½ hours to view. Videos are hosted through YouTube, which allows viewing at 1 ½ or 2 times the original speed. Test scores are not stored, as credit is not available for the course.

Mr. Hoffman presented the NEMSIS website, social media links, and help desk e-mail address. Mr. Arkins thanked Mr. Kinsman and Mr. Hoffman for their presentation.

Discussion

Mr. Estochen said that crash injury provide a measure of performance. He asked what role NEMSIS could play in increasing the accuracies of data based on police officers' assessments. Mr. Kinsman said police are not trained to accurately assess injury severity, and EMS clinicians are better qualified to make these assessments. The NEMSIS data standard also supports accurate data collection. ICD-10 codes can identify someone who has been involved in a motor vehicle crash. ICD-10 codes include an accurate definition of serious injury based on Revised Trauma Score, derived from systolic blood pressure, Glasgow Coma Score (GCS), and respiratory rate. This information may indicate probability of survival. The NEMSIS Technical Assistance Center (TAC) is available to explain the utility of these data to state agency staff.

Public Comment
Brenden Hayden, NEMSAC Chairperson

No public comment was offered.

Facilitated Discussion
Brenden Hayden, NEMSAC Chairperson

Mr. Hayden invited discussion of advisory topics or other topics. No comments were offered.

Vote to Approve Advisory Proposals
Brenden Hayden, NEMSAC Chairperson

Mr. Hayden noted that 20 advisories and 3 letters are in development and Council members have not proposed new advisories.

Vote to Mature Advisories
Brenden Hayden, NEMSAC Chairperson

The Adaptability and Innovation subcommittee Chair, Mr. Fifer made amotion to finalize the advisory, *Designation of Graduate-Prepared Paramedics as Federally Recognized Practitioners*. After the motion was seconded, the Council voted. The vote was in favor of the motion, with no opposition and one abstention.

Integration and Technology subcommittee Chair, Mr. Arkins made a motion to finalize the advisory entitled, *EMS Data Managers' Career Pathways*. After the motion was seconded, the Council voted. The vote was unanimously in favor. Mr. Arkins made a motion for the research subject matter entitled, *Best Practices for Use of Interpreter Resources in a Pre-hospital Setting,* to be accepted as a draft advisory. After the motion was seconded, the Council voted. The vote was unanimously in favor.

The Preparedness and Education subcommittee Chair, Ms. Basgall, made a motion to finalize the advisory entitled, *Large-Scale Events: EMS Planning and Preparedness,*. After the motion was seconded, the Council voted. The vote was unanimously in favor. Ms. Basgall made a motion to accept the research subject matter entitled, *EMS Response to Active Incidents: A Multifaceted Approach to Preparedness and Coordination,* as a draft advisory. After the motion was seconded, the Council voted. The vote was unanimously in favor.

On behalf of the Professional Safety subcommittee, Chair Carol Jorgensen, made a motion to finalize the advisory entitled, *Crash Scene Safety*. After the motion was seconded, the Council voted. The vote was unanimously in favor.

The ad hoc committee on Ambulance Crashes Chair, Dr. Mark Gestring, made a motion to finalize the advisory entitled, *Development of a Comprehensive National Ambulance Crash Data*

Collection Platform to Better Understand Current Crashes and Guide Future Preventive Strategies. After the motion was seconded, the Council voted. The vote was unanimously in favor.

Vote to Mature Letters

Brenden Hayden, NEMSAC Chairperson

Equitable Patient Care subcommittee chair Jason McMullan made a motion to finalize the recommendations letter to FICEMS entitled, *Prehospital Pediatric Readiness Project Support.* be promoted from draft to final. After the motion was seconded, the Council voted. The vote was unanimously in favor.

The Preparedness and Education subcommittee Chair Lisa Basgall made a motion to advance a recommendations letter to FICEMS on exertional heat emergencies and EMS response draft. After the motion was seconded, the Council voted. The vote was unanimously in favor.
The Professional Safety subcommittee Chair Carol Jorgensen made a motion to advance a recommendations letter to FICEMS on quantifying workplace violence against EMS providers to draft. After the motion was seconded, the Council voted. The vote was unanimously in favor.

Strategic Planning Discussion

Brenden Hayden, NEMSAC Chairperson

Mr. Hayden noted that all NEMSAC members have been appointed or reappointed through April 2025. Those with a reappointment are ineligible to serve another term. These members are Paul Brennan, Danita Koehler, Lisa Basgall, Mark Gestring, Thomas Arkins, Jason McMullan, Brenden Hayden, Carol Jorgensen, David Fifer, Suzanne Prentiss, and Ayobami Ogunsola. The following members are eligible for a two-year reappointment in 2025: Daniel Gerard, Mike Taigman, Wade Miles, Justin Romanello, Eveline Byers, Brandon Morshedi, Kendall McKenzie, Sylvia Owusu-Ansah, Casey Quintard, Tabitha Vaughn, Frank Quintero, Bradley Estochen, Michael Thomas, and Corey Condren.

Mr. Hayden thanked the ad hoc ambulance crash committee for their work and congratulated members for finalizing their advisory after 4 years of effort. Mr. Hayden announced the dissolution of the ad hoc committee following completion of its work.

Mr. Hayden invited additional discussion. There was none.

Review of Action Items and Wrap Up

Brenden Hayden, NEMSAC Chairperson

Mr. Hayden said this meeting's presentations were among the most interesting presentations made to NEMSAC. Presentations shape NEMSAC work and approach. The Council held productive discussions about what it would like to learn about from future presentations, groups it would like to invite to make presentations, and how it would like to increase public awareness of and EMS community engagement with NEMSAC. He thanked Council members, presenters, and Office of EMS for their work.

The next NEMSAC meeting is tentatively scheduled for August 7 and 8, 2024 in Washington, DC. *The Federal Register* will announce the meeting. Mr. Hayden encouraged Council members to subscribe to *The Federal Register.* He reminded participants that the Office of Emergency Medical Services portal for public comment is open and NEMSAC looks forward to public input on letters and advisories. NEMSAC's role is to serve as a voice for the EMS community. All draft and interim advisories are posted on NEMSAC's portal in pdf format. Advisories will be updated with changes tracked between meetings, so users should note the date associated with document files. Public comments shape all NEMSAC advisories. The portal also offers an interface for general comments, which are e-mailed directly to NHTSA's Office of EMS and shared with NEMSAC. Mr. Mole shared the link to the portal with the chat function.

Adjournment

Brenden Hayden, NEMSAC Chairperson

Mr. Hayden invited further discussion. Mr. Wijetunge said that the BIL created several new advisory councils for the DOT. The structure and work NEMSAC and Mr. Mole's approach to program management and activities coordination have served as models for new councils.

Mr. Arkin reminded the Council that May 19-25 is the 50th annual EMS Appreciation Week.

Mr. Hayden adjourned the meeting at 2:06 p.m. Eastern time.

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I hereby certify that, to the best of my knowledge, the foregoing minutes are accurate and complete.

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Brenden Hayden, NEMSAC Chairperson

These minutes will be considered formally for approval by the Council at its next meeting. Any corrections or insertions will be made in the minutes at that time.

Appendix A: NEMSAC Members in Attendance and Their Sectors

Tom Arkins, MSHI, EMT-P
EMS Data Managers
Indianapolis, IN

Lisa Basgall, MA, NRP
Local EMS Directors/Administrators
Houston, TX

Paul Brennan, BS, NRP
Hospital-based EMS
Lowell, MA

Eveline Byers, MBA, BSN, RN
Air Medical EMS
Spokane, WA

Corey Condren, MPA, PMDC (CA)
Fire-Based EMS
Concord, CA

David Fifer, MS, NRP, WP-C, FAWM
EMS Practitioners
Stanton, KY

Daniel Gerard, MS, RN, NRP
EMS Educators
San Francisco, CA

Mark Gestring, MD, FACS
Trauma Surgeons
Rochester, NY

Brenden Hayden, BHA, NRP
Healthcare Administrators
Portsmouth, RI

Carol Jorgensen, BS, NREMT, EMSI
Public Health
Elm Creek, NE

Danita Koehler, MD, FAEMS
Tribal EMS
Delta Junction, AK

Kendell McKenzie, MD
Emergency Physicians
Ridgeland, MS

Jason McMullan, MD, MS, FAEMS
EMS Research
Cincinnati, OH

Wade Miles, ABA, NRP
Volunteer EMS
Canton, GA

Brandon Morshedi, MD, DPT, NREMT-P, FACEP, FAEMS
EMS Medical Directors
Hot Springs, AR

Ayobami Ogunsola, PhD, FAC, CPA, CGMA
Consumers
Philadelphia, PA

Sylvia Owusu-Ansah, MD, MPH
Pediatric Emergency Physicians
Pittsburgh, PA

Senator Suzanne Prentiss, MPA, NREMT-P
Legislators
Lebanon, NH

Casey Quintard, BA, EMDQ, ENP
PSAP Call-Takers/Dispatchers (911)
Sacramento, CA

Justin Romanello, MHS, NRP
State EMS Directors
Hollis, NH

Frank Quintero, DO, MBA, FACEP
Emergency Management
Dobbs Ferry, NY

Mike Taigman, MA
EMS Quality Improvement
Santa Barbara, CA

Mike Thomas, DrPH, MHA, FACPE, NREMT
Private EMS
Beckley, WV

Tabitha Vaughn, MSN, RN, CEN, TCRN
Emergency Nurses
Indianapolis, IN