

Committee of the Central New York Emergency Medical Services Council, Inc.
January 14, 2010 Meeting Minutes

Name	Title	Present (X)	Status	Representation
<i>Members</i>				
Butler, David	EMT-B	X	Non-Voting	BLS Provider Cortland
Ciaccio, James	MD		Voting	Emergency Dept. Physician Community Gen Hospital
Clawson, Melissa	RN	X	Non-Voting	Emergency Dept. Nurse Tompkins
Darby, Warren	EMT-B	X	Non-Voting	REMSSCo Chair
DiGregorio, Anthony	EMT-P		Non-Voting	BLS Educator
Fields, Maryann	RN	X	Non-Voting	Trauma Center
Flynn, Shawn	EMT-CC	X	Non-Voting	BLS Provider Tompkins
Flynn, Susan	EMT-P	X	Non-Voting	ALS Provider Tompkins
Fullagar, Chris	M.D., FACEP	X	Voting	Emergency Dept. Physician SUNY Upstate Med University Hospital
Gascon, Cupid	MD		Voting	Emergency Dept. Physician Oswego Hospital
Hogue, Troy	EMT-P	X	Non-Voting	ALS Provider Onondaga
Jorolemon, Michael	D.O.	X	Voting	Emergency Dept. Physician Crouse Hospital
Koch, Drew	D.O., FACOEP	X	Voting	Emergency Dept. Physician Cayuga Medical Ctr.
Koenig, Paul	MD		Voting	Emergency Dept. Physician Auburn Memorial
Kowalski, Michael	MD		Voting	Emergency Dept. Physician VA Medical Center, Syracuse
Kushyk, Donna	PharmD		Non-Voting	Pharmacy
Lagoe, Ron	PhD		Non-Voting	Hospital Administration
Loomis, Bob	EMT-B		Non-Voting	Dispatch Personnel
Mackey, Jennifer	MD		Non-Voting	Pediatric Emergency Medicine Physician
Markham, Joseph	MD	X	Voting	Emergency Dept. Physician St. Joseph's Hospital
Merrill, Peggy	EMT-P		Non-Voting	AIS Provider Cortland
Morrison, Jerome	RN, EMT-P	X	Non-Voting	Emergency Dept. Nurse Cortland
Olsson, Dan	D.O., FACOEP	X	Voting	Regional Medical Director
Perkins, Barb	RN	X	Non-Voting	Emergency Dept. Nurse Cayuga
Ramsey, David	RN	X	Non-Voting	Emergency Dept. Nurse Oswego
Rathbun, Joseph	EMT-B		Non-Voting	BLS Provider Oswego
Sowles, Donna	EMT-P	X	Non-Voting	ALS Provider Cayuga
Wallis, Norm	EMT-P		Non-Voting	ALS Provider Oswego
Ware, Lucy	EMT-B		Non-Voting	BLS Provider Cayuga
Wirtz, David	M.D., MPH	X	Voting	Emergency Dept. Physician Cortland Memorial
<i>Staff</i>				
Eckstadt, Tamara		X	Non-Voting	CNYEMS Program Administrative Assistant
Jones, Jeff	EMT-P	X	Non-Voting	CNYEMS Clinical Consultant
Price, Colleen	EMT-P	X	Non-Voting	CNYEMS Clinical Consultant
Surprenant, Susie	NREMT-P	X	Non-Voting	CNYEMS Program Executive Director
<i>Guests</i>				
Jack Crouse				Oswego City FD
Robert Finger				Manlius FD
Naveen Seth, MD				EMSTAT, EASV
Brian Calley				TLC EMS - Brewerton
Al Kalfass				SUNY Aeromedical/WAVES
David Thomson				

Name	Title	Present (X)	Status	Representation
Jay Scott				EMSTAT
Derek Cooney, MD				EMSTAT
David Potter				Menter/EAVES
Chris Bitner				NAVAC

Olsson: All right, we'll go ahead and commence the January 4th Central New York REMAC meeting. A couple of housekeeping notes. Remember this is web cast so if you are going to make a comment please, make it into the microphone and identify yourself prior to speaking. If you're not going to make a comment, please be careful because it will get picked up by the microphone and it will be transcribed for the six people that are out there watching it. We have a number of substantially important issues that are going to have to go to Executive Session at the completion of this meeting. What that involves what that means is it will be a physicians only meeting. We have had a number of incidents that are extremely sensitive and extremely serious and so it's going to warrant a fairly lengthy discussion within that _____. Towards that end I would like to get through the public portion of the meeting as expeditiously as possible so that we can all get out of here at a reasonable time. Feel free to contribute, but I just ask that your comments be kept concise and to the point. The October meeting minutes were sent out electronically, and those have been reviewed. I will open up for any questions, comments, concerns, corrections or motion to accept. Don't everybody jump at once.

Unk: Motion to accept.

Unk: Second.

Olsson: All in favor? Opposed? SEMAC SEMSCo. The SEMAC met December 3rd – the 2nd of December and the SEMSCo on the 3rd. Some of you may remember that there was a discussion about EMS being able to give

immunizations because though the procedure IM injections is the same, it's considered not prehospital care because it's prophylactic training, however, the Governor signed a law that says EMS can be trained, provided they complete a six hour training module to learn how to give the IM injection. There are two regions that are doing hypothermia protocols after return of spontaneous circulation. This is out in Buffalo as well as New York City. They had two cases that had returned spontaneous circulation, one doc happened ED, return of perfusion, the other one, woke up, and was awake and alert and after a couple of days after notifying everyone that he was actually a terminal cancer patient signed his own DNR and died a few hours later. You may remember we have been having communication with the Cares Foundation dealing with kids with congenital adrenal hyperplasia and the use of Solu-Cortef. Solu-Cortef was placed on the State-wide formulary for use in kids with this acute crisis and diagnosis of that pre-existing condition. My conversation or communication if you will with the national group is that I want to know where these kids are. The expectation by the Cares Foundation is that everyone is going to start carrying Solu-Cortef. The reality is, we have we think two kids in our five counties, both of which live in Cayuga County and I just don't think it makes sense for us to carry that – another drug that we never use. The STAC has evaluated and made recommendations that in the future tourniquets will be used for uncontrollable hemorrhage. We'll see that come into play farther down the line. Monroe-Livingston have passed a two re-implantation protocol, that's kind of interesting. New York City is doing a demonstration project of orange

triage tags, those are for patients that are not quite red and not quite yellow, they're orange. The REMA region is going to be looking at intranasal Marcaine for BLS providers. Article XXX Part 800 recommendations for change that all BLS transporting ambulances carry some form of defibrillation and they all carry some form of epinephrine. PCR's are still in shortage. The Blood Council has gone back to the legal committee to reform another committee before it goes to public review to decide whether or not they can make a quorum to go to the public review to decide whether or not EMS can transport blood so more to come. Vital Signs is in New York City in 2010. Ketamine has been supported for use by the Bureau of Controlled Substances. There is still a long ways to go before it makes it into the formulary, specifically it has to go several steps, then it goes to Dr. Daines and there will be a policy statement coming somewhere. That is the gist of those meetings. Air Medical Service.

Darby: Air Medical Services met today. We had representation from all the North Country Life Flight, from their air medical agencies. We also had three regions represented, Central New York, North Country, and Midstate. We discussed clearinghouse statistics and a quick review of the trips that they had taken that Dr. Olsson looked at. We had only one audit and it was a quick audit from this last weekend on a rollover at 7:15 in the morning in Onondaga County up on 31 and Stearns, a 19-year-old with serious head injuries and we were told that through the clearinghouse Onondaga 911 to the clearinghouse, the Sheriff's helicopters in this county were not in service so they called Mercy Flight to see if they were available. They said they couldn't fly out of Marcellus because of weather and so they cancelled the air medical request, and then about 20 minutes later they got – Onondaga 911 called the air medical clearinghouse again to say cancel Mercy Flight so apparently called back to 911 directly and sent a helicopter out of Canandaigua. We had a

conversation with the Mercy Flight office indicating that we were concerned if they were going to send a helicopter and we did not know about it, had we had another air medical service in the air which is what we would try to do if there any in-service we would have multiple air ships, neither one knowing that the other was responding so we felt that was a safety issue that should be brought to their attention. Their thought was if it has been cancelled because of weather that the air medical clearinghouse should not even attempt any other helicopter. That is not our policy because we have air medical coming from all directions. If there is in fact weather somewhere within our three region area, there's often times that a helicopter can come in from the other side of the weather and give service. We had a visitor from Life Flight, they've got an expansion going on. Steve Anderson from Life Med, I should say, not Life Flight, of New York was here to tell us that they're expanding with a new air medical ship in the Hornell area and that they are going to be flying into two counties that are part of our 11 county region, parts of them. For the Central New York area, ours, it would be southern Cortland that they would be coming into, southeast Cortland, and for the Midstate it would be parts of Madison County, southern parts of Madison County, indicated right up front that they wanted to follow the protocols and go through the clearinghouse for those types of calls and that's about all we have to report. You've seen a lot of news since our last meeting with regards to the air wars. There was a Post Standard article back on the 4th of November done by a Mr. John O'Brien who interviewed Mercy Flight, State Police and Air One personnel and then did a two page article with 12 errors and it will be brought back to the editorial board saying if you're going to report this at least be honest and fair about the story and then News 10 Now picked it up and I believe it was Jolene Derosiere that was the reporter that was assigned to that and she did about a four week study of the problem, went all

over from Rochester with the Western Federal District Court to Albany to Canandaigua with Mercy Flight. She went out to our shop, she was visiting us with all of our stats, went to clearinghouse and actually sat in the clearinghouse dispatch center and watched how that functioned and did a three part series, Monday, Tuesday, Wednesday, following the Christmas Weekend that was about as objective and neutral I've ever seen a reporting being done. We're getting a copy of that series and we will make it available to you if you were unable to see that series. It was News 10 Now which is a Time Warner Cable, so you may not have that. So there is a lot of talk in the community about the air wars. The titles of the articles and titles of it shout the actual message, it is kind of whispered, but it's there and we're doing good EMS and air medical.

Olsson: Thank you. Any questions for Warren? Okay, Susie.

Surprenant: The CQI report will be given in Executive Session. For the Program Agency report, since we met last what occurred in November that was a big discussion at Council meeting was the Program Agency funding actually across the State. There were several regions that had not gotten their contract. Everybody's contract was suppose to be started 07/01, but through the provisional budget, holding up funding that what happens is that the Comptroller's Office was not releasing the contract or processing it in vouchers or advances. Since then all the contracts have been approved. We got ours last week as well as check and it did cash so that's a good thing. What that would have impacted is we would have been able to operate until the end of January. There were some regions, Binghamton, Susquehanna being one of them that would have been closed December 1st which the Council has a separate funding source, but the REMAC was funded through our contract so that would have affected some of the functions of the REMAC

so that was cleared up. New York City which was one of those that did not have a contract cleared up _____ make sure that happened so they were very delayed compared to last year's so all of that has been resolved and resuming business. The other piece that came up was the PCR shortage. They ended up having not to disburse any PCRs to BLS and FR agencies, and basically the ones that we did have in stock _____ 50% of our stock which is 5,000 and we always order additional so we always have close to 10,000 on board which gives us, if everybody ran out yesterday we have like a month and a half supply so the nice thing I talked to _____ yesterday and there was suppose to be a truck load arriving yesterday. Tammy confirmed that with the staff member that takes care of those who processes our order is that they started arriving so we're hoping that it will be processed in the warehouse and by the end of month ____ we can begin to start dispersing PCRs to the BLS and FR agencies. The ALS agencies and the ambulances were not affected because they had enough supply, but we will be able to supply everybody again with PCRs. Hopefully we won't have this for another ten years. There is an instructor update that's occurring on January 23rd and it's _____ training. We found out in the regional CQI that there will be tentative date for May 19th as an EMS teaching day. Last year we had one sponsored by St. Joe's, one sponsored by University. This year we're told that it's going to be a combined effort between Crouse, University and St. Joe's. So there will be a posting and getting as much as information and giving that to providers so it's well attended. The last two last year was very well attended at both teaching days. We had a lot of good comments from the providers. And then as happened in November for anybody that didn't know Ed Wronski was the Director of the Bureau of EMS retired and Lee Burns right now is acting director and we found out that was an appointed position so hopefully that appointment will become permanent.

Olsson: Any questions for Susie? Part of the regulatory nature of the State requires that we read into the public record those who have violated the Public Health Law Article XXX, Robert Hanson surrendered his certification for violations of Part 800.15, 16 (a) and (b), Julio Otero, certification was revoked, Part 800.16(c) and (d), Christopher McCabe, EMT-B certification, suspended 3 years with a stay, EMT-P certification suspension 60 days, probation 3 years, civil penalty \$2,000, violation of Part 800.15 and 16, Court Cousins suspended 1 year, civil penalty \$1,000, violations of Part 800.15, 16(a), (b) and failure to comply with a previous stipulation and order. Old business?

Surprenant: I will read the updated list of agencies that submitted paperwork to have their BLS providers _____ monitoring. So far we have got 13 CIMVAC, we've got Cornell, EAVES, Mattydale Fire Department, Minoa, NAVAC, NOVA, Menter, Pompey Hill Volunteer Fire Department, Throop Fire Department, Trumansburg Fire Department, Weedsport and WAVES.

Olsson: Okay, new business. Interfacility form. A question came up six some odd months ago regarding specifically interfacility nitroglycerin and when we looked at the protocol book, if you go and look at it, nitroglycerin does not fit in the IV drips section. We traced – Susie traced it back to 2001 where it was moved from paramedic up to critical care and it was suppose to have been included, in other words, indented one tab over which would have put it under the IV drips. Due to #1 a typographical error that inset never happened, #2 that change never went to the SEMAC. It was something that was done within the body of the REMAC and somewhere along the line, Dr. J sent a letter or a memo, said, yeah, go ahead and do it. So we caught wind of that and in November – December we _____ and tried to figure out how we can get around it. And the reality is that as

far as a protocol goes, we can't. It has to come back to this body and it has to go through the appropriate approval process. In the meantime, however, with a physician order we can do it and that's where this particular interfacility form came into being. It started out as a nitroglycerin drip form, in reality it is something that we ought to consider looking at for any interfacility transfer. My guess since I don't normally do them is that the order that is given EMS is scribbled on a prescription pad, a note pad, or yeah, go ahead and give this until something bad happens and then turn it off so this is something that we need to look at.

Surprenant: There are basically four agencies that are doing a majority of the interfacilities so they started using these forms for nitro drip and actually a couple of agencies and then hospitals asked can this be used for all interfacilities so that was the discussion that occurred today. Dr. Koch, I understand that you're using that for all interfacilities?

Koch: Yes.

Surprenant: And how is that working?

Koch: Good.

Surprenant: So from the REMAC physicians in the room, your opinion?

Wirtz: I think it's great that we're going to document the orders there, and you know, to validate the transfer. I didn't realize this was just suppose to be for nitro, I've been using it for everything so I think you need more space on there because we had a patient last week who had three different drips and ended up kind of scribbling on the sides and stuff so I think we need to maybe rework this a little bit, but it's _____.

Olsson: It started out as nitroglycerin, but one of the reasons it ended up this generic was for

that reason. One of the things that we looked at when we made this up was not only simplicity, but legibility, and my concern would be is you have – in theory you put three or four drugs on here, but then it just might get too cramped, and I have to wonder if one form per drug might be, even though it's just another couple of pages, it might make it more legible and more clear, otherwise you don't have people trying to cram writing into the form.

Surprenant: Any other discussions from physicians that work in the hospitals? We haven't received any negative comments on this so far. So far it's all been positive, there's a little bit cleaner way and it's one form that used by all nine hospitals so each hospital doesn't have a different procedure and that EMS is using the same form throughout the region. So we've actually received good comments from that.

Olsson: So we will entertain a motion to incorporate this particular interfacility transfer form into the standard documents that individuals performing interfacility transfers would utilize.

Markham: So moved.

Olsson: Dr. Markham. A second? Dr. Koch. All in favor? Opposed? Carried. Thank you. We have an application for a service medical director, Dr. Gerald Simmons, who is applying for the City of Oswego. His primary certification is family medicine. The City of Oswego is ALS ambulance, ALS first response. He was a basic EMT in the early 1990s with SAVAC, SUNY Oswego. Under the checklist, he has completed a review of the policy statement providing medical direction, review of the policy and protocol manual, review of the CQI manual. He is pending the review of the on-line medical control program. He has signed his agreement. He's signed the medical director verification for the Epi, albuterol, glucometry,

A-EMT. His resume is Family Practice St. Joe's, medical school was SUNY, bachelor's SUNY Oswego. He was in the emergency department in Oswego, June through November 1999, Oswego VA Clinic July 2000 and has been family practice since August 2000. He is boarded in family practice. He's taken ALS, ACLS. He is an affiliate of the Medical Society of New York, active staff Oswego, courtesy staff Oswego, and affiliated with the American Academy of Family Physicians. Chief Krause, you're familiar with Dr. Simmons, would you like to say anything?

Krause: Dr. Simmons is a local physician in our area. He's very familiar with our EMS system. He doesn't bring a lot of experience with him, but he brings a lot of interest in the field and he would like to get very involved with our service. He _____. We've not had up to this point a one-on-one involvement and I look forward to working with him.

Olsson: Questions, comments, concerns about moving forward? Okay. Is there a motion to accept Dr. Simmons as the medical director for Oswego – City of Oswego Fire Department pending his completion of the on-line medical control program? Koch, Dr. Markham, all in favor? Opposed. Passed. This will gain much more relevance in the next hour for the physicians. Okay, service upgrades?

Surprenant: We've got two tonight to discuss, SIMVAC and Aurora Volunteer Fire Department. CIMVAC currently has three EMS vehicles that are BLS, personal vehicles, but they are stickered by the State. They would like to go to ILS for these vehicles. This agency is in Cayuga County and I think they have an ambulance as well as two ALS first response agencies that only have a BLS provider. So they're asking to upgrade their three vehicles. They need an inspection and that will come up to vote. The other one is Aurora Volunteer Fire Department is asking to operate at the ALS

paramedic level. They currently changed ownership. They were a volunteer fire department and they're a newly formed taxing fire department, they're Aurora-Leland Fire District, that at the insistence of DOH they've directed the Aurora Ambulance to operate only at the BLS level until the region approved the Aurora-Leland Fire District to operate at the ALS level. The current medical director is Dr. _____, he's been _____ agency for seven years, is supporting this ALS and is involved with the agency. They currently have one critical care tech, and an EMT that is going to be completing the paramedic program and testing out in May, and they have two other members, one a physician's assistant and one a registered nurse that are looking into the paramedic program. They're located 20 miles from Auburn, 35 from Ithaca, their closest paramedic intercept origins and given the distance for ALS intercept, they believe that it's the best interest of the community to become an ALS ambulance. And they're ready for inspection and they're requesting permission to upgrade.

Olsson: They have one critical care tech, one soon-to-be paramedic.

Surprenant: Yes.

Olsson: I mean they're currently at the BLS level?

Surprenant: They were previously an ALS ambulance at the paramedic level, but due to a change of ownership and the name change the DOH said they had to go down to BLS until they get to this body because of their ALS status.

Cooney: When they were an ambulance service, an ALS ambulance service, how many ALS providers did they have?

Surprenant: I'd have to look back. Donna?

Sowles: Two.

Olsson: One CC, one paramedic.

Surprenant: Okay, thank you, Donna.

Olsson: So now they have one CC and one almost paramedic?

Sowles: Yes.

(_____)

Olsson: So if they hadn't changed the name we wouldn't be doing this?

Surprenant: Correct.

Olsson: And this is pending investigation – inspection?

Surprenant: Yes, and then this body's approval.

Olsson: Okay. All right, so there you have it. They've had a name change and now they're forced to go through an approval process. We will perform an inspection and if that inspection pans out and this body approves then they can resume their ALS status. Do we know if there have been any incidents in the past regarding this agency?

Surprenant: Not in the last three years, no.

Olsson: So they've been clean for the last three years at least so. Okay, so we'll need a motion to approve their return to ALS status pending an inspection.

Wirtz: So moved.

Olsson: Second?

Second.

Olsson: All in favor? Opposed? Carried.

Olsson: CIMVAC, they want to upgrade their EASBs to ILS and a similar thing pending inspection, obtaining approval from this body so the same motion to approve CIMVAC's upgrade to EASB to ILS. Dr. Fullagar, second Dr. Thompson. All in favor? Opposed? Olsson: Abstained? Carried. Thank you. Okay, Solu-Cortef is under here as new business. Pretty much as I mentioned, I sent a letter on December 17th to Dina Matos, Executive Director of the Cares Foundation about the use of Solu-Cortef. As I have mentioned ad nauseum at previous meetings there are theoretically two kids in our area that have this. They are both diagnosed with it. They have the Solu-Cortef in their home. They have the syringes and they have the doses. The question that is going to be put before this committee is do we as a region start carrying Solu-Cortef or do you wait for the Cares Foundation or the local physicians to tell us where those kids are and we will tell those agencies where they are so they can take care of those kids. Consensus?

Thomson: What do we need to do so that our providers could administer the drug assuming that the parents have --

Olsson: Right now, technically nothing. The most they would have to do is pick up the phone and call med control and it's most likely going to be Auburn, that's my understanding where they live and say, yeah, we have a kid with known adrenal hyperplasia that needs Solu-Cortef, it's right here and it's an IM shot, done, they roll the kid, they give the shot and put the kid in the ambulance and they take them to the hospital.

Markham: If that's the case, it doesn't seem that we should have to that in our rigs in all the regions just to manage patients who already have the medicine at home. It's a big deal to

add to everybody for something that was probably not _____.

Olsson: And that has been my contention and if that's the consensus then I'm just happy to go with that. I told you that at the SEMAC there was a lengthy debate about agencies that carry Solu-Medrol, hydrocortisone, and is there enough of an overlap and the answer is no, there isn't. So those agencies that carry Solu-Medrol and if they want to carry Solu-Cortef it's another drug so my preference is to, by the way I haven't heard a word, is to find out where these kids are and let's take care of the kids that need to be taken care of rather than blanket treatment in the whole region.

Fullagar: I am wondering if we were going to -- instead of going this route, if it might not be a bad idea to have a communication with Auburn Hospital just to let them know that this is what we discussed and to remind them that they have the authorization as medical control to authorize the paramedics to do that.

Olsson: Yes, that's easy, we can do that. When this first came up, when Dr. DiRubbo was here, she nodded having knowledge of that. She was aware of these kids, but we certainly we can have that communication, that's easy to do.

Surprenant: Jeff, Colleen and I were discussing the progress of the regional CMEs wants to be switched to a scenario base. There was two other things we would like to see with the opinion of this body, we continue to see _____ medication errors which we have discussed several times at the REMAC meetings and ways to try to prevent some of the issues. One of the things that we still deal with is the fact that agencies do not have to look at their controlled substances because they're in a locked box, _____ medication checks in a vehicle where you look up the medication, check the expiration, the dosing and one of the thoughts and we do have some agencies that are doing that, but they

do CMEs they actually do look at medications that have two _____ of saline so they actually put the device together and actually look at the concentrations that they carry. Instead of doing that – where some agencies are doing that and some aren't, since we still see errors we would like to develop an educational component that becomes part of the regional CMEs where people who review their controlled substances every six months, but with concentration to make sure that nothing has changed, and actually see what they're carrying besides _____ seal. So we would like the physicians' opinion on that. Jeff or Colleen, do you have anything to add to that? John Morrissey.

Morrissey: John Morrissey, State Health Department. A friendly amendment to that thought, since one of the problems that our office is finding when we get cases for controlled substance issues is they're also very unfamiliar with the agency's paperwork, how they account for it, how they instruct for it, so a friendly amendment would have the agencies that are doing that _____, frankly, a lot of times it's they got the med wrong, they got the paperwork wrong. That's sometimes the big hassle, along with other hassles, just a friendly amendment.

Surprenant: Any other comments?

Price: From a standpoint of what we do, I think a couple of times _____ they're sealed the metal boxes so the ability to be able to get _____ some what to manipulate the tools to play with them would be great, and we can incorporate it in a couple of different ways, it just doesn't need to _____, as we all know how that goes, sometimes as far as retention, they can also be put into and this is what John was talking about, different ways so that it's not always presented the same way. So if _____ they can be put into medication _____ so lots of different ways to incorporate it. I think what it comes down to is we have had to pull

paperwork _____ that really do need to be addressed _____.

Surprenant: Do the REMAC physicians feels that this is of value to add to the regional CME requirements? Dr. Markham?

Markham: Joe Markham. I do. I think we've had this discussion before and I think it's a great training experience for the medics to continue to verify what they have, there are different appearances and the different syringes, it's a closed box. The only time that they see it is when they open the box and they can go for months and months and months with never opening the box and it's good to just refamiliarize with these medicines since they are very potent medications I think it's a good idea.

Surprenant: Can we have a motion on the floor? Dr. Koch?

Koch: That it be a part of the CME practice.

Surprenant: Yes.

Olsson: Second? All in favor? Opposed? Carried.

Surprenant: This first set of training _____ to the agencies that was a part of the regional _____. The other discussion that we had was ways to better utilize our upcoming CQI. We discussed that on Exec and we've discussed it on regional CQI _____ protocols, especially since we have some new ones and have county CQIs and agencies submit protocols so for example, patient restraint so the first quarter agencies that would attend CQI committees at the county level would bring examples of how the protocol was utilized and just review it to make sure that it is being done correctly, if there are any common questions coming up that need to be addressed by the region that we have that. Especially some of the smaller agencies from our smaller counties where we don't have a

_____ time line, some of these agencies may never use these protocols so it would also be a good way for them to review that. Besides having issues, bring back some positive feedback to the region on protocol usage. So that's something we would like to reach out to the county CQIs and include that as part of the feedback they give to the regional CQI and the REMAC _____ protocol. So we will reach out to the county chairs on that.

Price: Susie, were we going to wait until April to discuss the topic _____

Surprenant: Yes.

Olsson: A while back we put in a protocol for RSI. This has been an ongoing and lengthy discussions over the last several years. It was put into the protocol in the last review because we knew that we were having a major protocol review at the time and it was an opportune time for us to get it into the paperwork and through the SEMAC especially since now that the SEMAC has gone to three meetings per year it is going to significantly lengthen the approval process. Our intention is to get those providers who are involved in the air medical services through it first. I think this was the most reasonable use of training and personnel. We as you remember developed a very lengthy policy statement on it and we have two agencies that are looking at starting a training and education process of that, NAVAC and WAVES, who are obviously two helicopter agencies. We need to again look at and review what they're doing and

Surprenant: Due to the Executive Session that we do need to go into, we do have the applications for the providers, for both WAVES and NAVAC, we would like the approval as REMAC physicians to send those to you electronically, get your feedback electronically and have approval for those providers so we can have them start training and not have to wait

until the April meeting. So instead of reviewing that tonight and looking at them, but still that done by this body, but do it in an electronic format to see if that's okay and if the process works in the future when we do the ground services we can provide those ahead of time to this group so when we come to a meeting we just discuss the content of those.

Olsson: You need a microphone, please.

Markham: I agree.

Bitner: When would you like to start this -- in order to be doing this electronically at a later date, when are we looking at a start date for --

Surprenant: We can have them out to you Monday.

Bitner: Okay.

Surprenant: What we don't want to do -- we need to get RSI for Air Medical, and we all know the reason for that, is not to delay, potentially to have delayed training, _____ so we've got the completed applications, they were delivered today to us, and we've got a few more coming in from NAVAC, but we don't want that delayed so all we've got to do is scan it and send it _____.

Kalfass: Al Kalfass, WAVES ambulance, so once the credentialing is approved, we're good to go with this protocol is that my understanding?

Olsson: Well, there's credentialing of the training program and Dr. Fullagar and I need to chat about that.

Kalfass: Okay, I'm just trying to figure out a start date so we will have the date we're good to go.

Olsson: To start the training or start the use of it?

Kalfass: Once the training is complete, and the individuals credentialed, we can start the protocol.

Olsson: That would make sense, yes.

Kalfass: Okay, that's just what I want to make sure. Thank you.

Surprenant: The Regional CQI Manual has been updated to reflect the changes that were made in the State, the State Manual added a bunch of appendices which were helpful CQI tools for agencies to use. We've done the same with the Regional CQI Manual, we were going to be reviewing that tonight, but since we have two – actually three protocols for review before we go into Executive Session, what we're going to be doing is sending the REMAC physicians a scanned version of that and just highlighting where the changes were made to reflect with the State so you can have that to review and have any comments for this body and then we will bring that back in April for a final vote and review any of the comments that are made. Colleen?

Price: For ease of getting things updated and back out if I could have some of the stuff back probably in mid March so I can get it back out for the April 8th meeting.

Olsson: All right.

Surprenant: Jeff is going to run the computer and we're going to actually put up, we'll discuss the CPAP protocol and we will do the same thing that we did with the other protocols where you're going to be able to see it electronically and so we can make any changes that need to be made.

Olsson: So those who have been around for a while CPAP prior to the last revision was discussed, it was thought that at that point in time there wasn't enough support for it, or whatever reason it did not make it into the last revision. Since then, _____ support and so I think it's reasonable today to go ahead and revisit that particular intervention and/or device. So the purple highlights are the changes and the non-purple is as before. So one of the first things to look at or to notice is that it doesn't really matter what the respiratory distress is due to. If they're in respiratory distress, would they benefit from albuterol and then would they benefit from CPAP. If that's the case, then we would just follow down through the algorithm. Jeff, can you change that purple to yellow? It's a little tricky to read. So the questions that are being put forth as #1 is CPAP something that this region would like to have as an agency option. The reason that it would be an option is primarily due to the cost. I don't know what it is, but I'm guessing it's pretty hefty.

Cooney: \$78 a patient for oxygen _____.

Olsson: And then where does it fit in the protocol and then the third thing would be whether we limit it to a known diagnosis of asthma/COPD or do we just leave it open to anybody who is having trouble breathing. Dr. Fullagar?

Fullagar: I think it's pretty clear that, it is subsequently used on a national level, that there has been _____, there was some pretty significant patient outcome data in regard to that. I think that since the last time we discussed this there have been many more devices that have been coming out on the market that are specific to prehospital care or EMS, _____ what Dr. Cooney is talking about is a disposable device that can be used per patient. I think we probably should not limit this just to asthma or COPD. I think that there's a lot of use for patients for example who are in congestive heart

failure and they may actually respond better to CPAP than the rest of the group, but I think this is definitely a time to move on this.

Olsson: Actually the next protocol that we will at is the pulmonary edema one which in fact has it. Dr. Landsman.

Landsberg: Just to expand on Chris' comments. We talked a lot about airway and airway control. We're going to talk more about it later we all know. I mean I'd like to see this personally as a rescue as well. This is a great crutch. If you can't get that tube in, you are very likely to have an oxygen change on a patient that's 20 minutes worth to get to the hospital from wherever you're coming from in this region. I think it is _____. I think it's a great tool to have.

Olsson: Dr. Cooney.

Cooney: In general, I think I just would be reiterating the other things about whether we should have it or not, but I would like to comment specifically on what's on the screen here. We have contraindications basically if they consider CPAP, if the patient is and remains alert, that's an obviously one, is able to follow commands, that's again goes to mental status basically and then no history of pneumothorax. I'm not sure that's a perfectly good contraindication with an ALS provider. We have to assess for pneumothorax, what we don't have on there is vomiting patients and hypotensive patients. Hypotensive patients can have positive airway compression ventilation from CPAP because it's known to reduce the reload so we need to think about that. So if you have an acute MI patient with pulmonary edema, they've had a right inferior wall infarct and they're hypotensive and we put them on this, we'd actually do them damage and then vomiting patients, I don't know if anyone has ever seen, actually I don't know if it's unusual or not, there's actually a nice video of a patient

being put on BiPAP and they vomited in the mask, the vomit disappears and you don't have to guess where it went. So those are two contraindications that I would like to see listed there.

Olsson: Dr. Thomson.

Thomson: Just a comment about the fact that they've got to have had other modalities fail essentially before they're allowed to consider CPAP. I think that there's a number of these patients especially that CHF or _____ for them to have to go through an albuterol/Atrovent trial and wait 5 minutes and things like that, I think it does the patient a real disservice and I think it would be better to allow this to be at the paramedic's discretion, let them go straight to CPAP because it may be that CPAP can be combined with the beta agonist and so forth to really improve that patient's outcome, but if we make them do a trial sometimes they never get to the CPAP.

Olsson: If we move that consider CPAP box up and put it parallel with the right hand box, so that it would come down and it could go either way and then in an educational piece for patients that are speaking in two to three word sentences, actually moving air, treat them with albuterol and then if they are in extremis or trending that way then go straight to CPAP.

Thomson: That sounds like a very _____.

Olsson: Dr. Landsberg.

Landsberg: To echo that, I mean it's a ventilator so I mean you should meet criteria for intubation except for that fact that you're awake because I mean that's how you and I use it every day, that's how we're using it and that I think is the niche for this. If we can avoid intubating them in the field in someone who is awake, but is basically in respiratory failure, that's your patient. I mean if you're still tachypneic and

you're feeling crappy, I would like to just neb you, neb you, neb you, neb you rather than put on a CPAP actually. I think no relief after 5 minutes, I'm still tachypneic, I'm saturating well and my mental status is good, I don't know, CPAP is not free either, if they throw up you don't know what's going to happen. I'd like to see them basically qualifying for ET tube, if not for the fact that they were awake and controlling their airway. And I think that's your best population, that's our _____.

Olsson: Dr. Markham.

Markham: Joe Markham. I'd like to add a little bit more to that. I agree with Dr. Landsberg said. I wonder if this protocol isn't the perfect spot to have a discussion about using wave form capnography on your awake patient and not just intubate the patient. In a case like this, particularly if you're going to use this prior to intubation, once you put that mask on it's going to be more difficult to communicate with the patient. Using wave form capnography on a patient like this that is awake will give you early warning to know if that patient is getting better or worse or unchanged, and it would be a great tool to show whether you're gaining ground or not.

Olsson: Okay, so far we have to topics of discussion, one is whether or not to move CPAP up higher up the algorithm, leave it where it is and then second issue is capnography. So –

Wirtz: Just a small third topic.

Olsson: Thanks.

Wirtz: No problem. Is that excluding CHF, I'm just thinking that, you know, albuterol is not _____ for CHF. I know it says it is in the protocol _____.

Olsson: Currently, pulmonary edema, we also switched those to _____.

Cooney: The other wrinkle in that since you made wrinkles _____ I was just informed me by the physician behind me that we have epinephrine on protocol _____ and if we're going to make acute respiratory distress and all _____ treated _____ and epinephrine is probably not the end point because of heart failure. So we may want to have a more generalized protocol, we would have to rethink maybe that end point medication. I think it's okay to give an agonist and _____ beta agonist to someone you're not sure, but maybe epi is not what you should give if you're not sure. So that is a further complication to that. _____

Olsson: So here we're looking at the pulmonary edema one, so if blood pressure is over 100, nitroglycerin and going to CPAP fairly early on, still nitroglycerin is an early intervention. Can you just – that's the whole thing right? Is there anything else that we're just not seeing that -- there is also now the question of whether or not we take out the second Lasix dose. Lasix is falling farther and farther out of favor so, Dr. Cooney.

Cooney: I think you just said part of what I was going to say. I'm not even sure that prehospital Lasix, and I'm the director for NOCA and by the time they hit the doors at Syracuse hospitals that might actually be a death, but certainly in the city I don't see anything that you're doing with furosemide. I mean there are a number of cases I've seen, reviewed, the patient had pneumonia and getting a diuretic which is a very bad thing to do, and I'm not so sure it's just going to give us the type of effect with prehospital. I personally believe that if you have nitroglycerin in an adequate dose and CPAP there's no real added value for furosemide. I would say that I'm a little nervous and we have to talk about it in the educational piece, a 100 blood pressure in an average adult plus nitro and plus CPAP, would do what I'm referring to as hypertensive patient

shouldn't have CPAP. But that might be better addressed in the educational piece than in the wording of the protocol. I just wanted to throw that out there.

Olsson: So what would be a reasonable pressure that people would like to see.

Cooney: Well, personally, I use about 110, but if the patient is in pulmonary edema, that's the patient we're treating, I actually honestly would like to see the pressure higher because I'm assuming there's the potential for a huge infarction of the heart which is the patient that you really don't want to preload from. ___ so that's why I say maybe it's not the best place to put it in the protocol, but perhaps address that in the education piece. Over 100 is probably a reasonable _____. I'd like to hear what people think about that.

Olsson: Dr. Landsberg.

Landsberg: _____ not getting into too much of a physiological discussion. If the blood pressure is 140 and your sat's 80, I'd rather have a blood pressure of 80 and a sat of a 100, so there's wiggle _____, you've got to be a little bit careful. Yes, the positive pressure is probably going to drop a bit _____ an issue regarding CHF _____, but even if the blood pressure is good and there's no oxygen perfusion _____.

Olsson: I agree. I don't think we're going to have an answer right now. I think that's oxygen where the 100 came from over the years. One thing that I just noticed is not on there, perhaps we should have it as the bottom line and if this would be part of the teaching, if CPAP is utilized notify medical control as soon as possible which they should be doing anyways. I don't think any of us would want one of these patients roll through the doors with CPAP on that we don't know about. So in this pulmonary edema protocol, taking off the 80 of Lasix, the

protocol as written, as this agreeable to the physicians in the room? Dr. Cooney?

Cooney: I still want no vomiting in there, that's a big one –

Olsson: No history of pneumothorax or active vomiting.

Cooney: I could live with that.

Olsson: Okay. Will you just type that in, Jeff? After no history of pneumothorax or active vomiting. Jay?

Scott: You might just want to write into the protocol, if you really do have that patient that is hypotensive or borderline hypotensive, you consider CPAP _____ early on.

Thomson: Then just down at the bottom, notify Onondaga County medical control as early or as soon as possible or immediately or something.

Jones: Why don't we rework the whole thing and make all those changes to the other one as well.

Olsson: Well, the other one is going to be a little more complicated because I think – is everybody okay with this one? So all the physicians that approve raise your hands? Opposed? It's carried. So that's all right. Now, if we can go back to the asthma, COPD, the same thing with no history of pneumothorax or active vomiting and then the question is going to be where to we put, does everybody get a trial or do we put a little dotted line in the teaching, intubation is in extremis go straight to CPAP? Dr. Markham?

Markham: I think we move out. If Air Medics has to make an option right now, whether they intubate a patient and I agree with what Dr. Landsberg said, this is the same, essentially same treatment. Well, they're _____ I think they

should have the option to use what they feel is appropriate and you just have to make in the education program is appropriate.

Olsson: Jeff, can you take that box and move it up and move that other one, scrunch it?

Jones: Uh... maybe.

(Laughter)

Jones: We'll make it look pretty.

Olsson: So moving it up and putting it on a horizontal level with the first on the right hand side and the educational piece they'll make the decision, extremis to not an extremis, which way to go knowing that they can go back and forth somewhat. Then at the bottom the same caveat, call medical control as soon as possible or immediately. Dr. Fullagar, is that a yes?

Fullagar: I would say yes. I would say as soon as reasonably possible because I would rather the patient be treated than having to make a phone call. _____

Olsson: Correct, and it's stated elsewhere in routine medical control anyways but it never hurts _____.

Wirtz: Does anybody know how easy it is to put albuterol and atrovent through these prehospital CPAP machines?

Olsson: Dr. Cooney?

Cooney: Actually pretty easy. The only difference is _____ \$78 because it is an added cost _____ require a second oxygen supply so you'll have to use your bottle from your bag or a second bag to run _____.

Olsson: Dr. Markham?

Markham: If we're going to have any further discussion about that, I would capnography. All the ALS agencies will have it.

Olsson: I'm wondering if there shouldn't be a blanket statement somewhere about the use of capnography on all patients in respiratory distress, which can come out as a policy statement.

Markham: I think that would be a great addition to prehospital care.

Olsson: Dr. Fullagar?

Fullagar: I think that definitely should be in the educational component of this. I'm a little cautious about absolutely starting to write it into the protocols or requiring a policy, again I think it's a tool that's a useful tool in some cases, but again there's a lot going on, there are other priorities that I think need to be addressed, I'm not sure that using it on every single case would be the way to go, but definitely certainly _____ to maximize your care for the patient that's definitely a good tool to have to monitor _____.

Olsson: So we could put that into _____ --

Wirtz: Are medics allowed to use it any time they want to?

Olsson: It's mandatory for intubation. It's not mandatory any other time. John Morrissey in the back.

Morrissey: The only thing I might point out is that not all capnography machines keep _____ intubation or _____ crossover. You may all of a sudden _____ requirement _____ a lot more money.

Olsson: So we may have to include tidal CO2 capnography should be used when available.

Markham: consider capnography used in any patient with respiratory distress and let the medics decide, we may never need to use CPAP or intubation, and still get good clinical data.

Olsson: So we could put that sentence in.

Wirtz: I agree with that.

Dr. _____, do we have to have a blanket statement that you could use that anything with an OPA or NPA use requires measurable wave form capnography, including BVM and combitube in January of last year.

Olsson: Say again, I couldn't hear.

I think we have a blanket statement already from you that says anything, paraphrasing, beyond an OPA or NPA insertion requires measurable wave form capnography, isn't that correct?

Olsson: It should only pertain to intubation and intubation _____.

Fullagar: Intubation _____ I don't believe it applies to BVM because _____ OPA or NPA and I don't believe that CPAP would fall under that either. At least in my mind _____.

Olsson: I think it was only for advanced airway devices.

Fullagar: Okay.

Olsson: Colleen?

Price: This is something that probably _____, right now this reads CC and EMT-P, _____ decision _____ we don't _____ CC's, the way this reads right now _____ where we haven't done that with all the other stuff. I just question on how that is going to fall out. Because right now

everything we're doing applies _____, but that's not necessarily the case _____ decisions _____.

Olsson: Dr. Thompson?

Thomson: This is not that complicated of a device to apply. I know that one very busy municipal firefighter EMT-basic service _____ that have no difficulty with the basics using it. I think that critical cares and paramedics would have no difficulty whatsoever and intermediates would have no problem at all using this CPAP device.

Olsson: As far as the basics and intermediates, we'd have to go back and look at their State curriculum and see where it fits.

Price: It's not in the State curriculum at all.

Olsson: It's not in the curriculum, all right. So barring any lengthy discussion on that it would not at this time be applicable to other than CCs and paramedics.

Morrissey: Just one clarification. It's in the paramedic curriculum. It is not in the intermediate or cc curriculum.

Olsson: All right. Okay, so we're talking paramedic only for CPAP.

Price: That's what I'm asking because the protocols that you're working with are CC/paramedic, but the curriculum doesn't lend itself that way. That's what I was asking.

Morrissey: Right, understand that when the critical care curriculum was created, CPAP was not an option where the paramedic curriculum has that statement about other new advanced airways, it was kind of open ended. It was not that open ended when we wrote the critical care curriculum. I don't know off the top of my head, I'd have to go read, SEMAC they approved for

critical cares to get it, okay, but I'm not quite sure where that is in the scope of practice document. I'd have to go a little research. I don't know it off the top of my head.

Olsson: Well, one thing is when it does, it has to go to the SEMAC anyway, we can leave it as a CC/paramedic and then we can let the SEMAC tell us we can't.

Price: No, we do that with the intermediate –

Olsson: We'll just take it then and let them tell us no. Dr. Wirtz.

Wirtz: So going along that line of thinking, do we want to include intermediates on that thing?

Olsson: That's beyond the scope – no.

(_____)

Olsson: I can only sweat so much. Okay, so, physicians, are we comfortable with this protocol as written. All in favor?

Wirtz: I just have a question, do we want to have this exclude CHF specifically –

Olsson: It excludes CHF by virtue of the fact that there's a pulmonary edema protocol so there's no reason to say – Okay. Dr. Fullagar?

Fullagar: So why are we changing it to respiratory distress, taking out the asthma _____ portion, I'm a little confused.

Olsson: To make it more generic.

Fullagar: Okay.

Olsson: I don't want somebody to say, well, I have bronchitis, they have bronchitis, I can't breathe or – I don't think that the field provider should try to determine is it asthma, is it COPD, is it pneumonia, is it this, is it that?

Markham: I am just concerned that people may look at that and read that as it is superceding the CHF protocol, in some cases, I just think that's open to confusion.

Olsson: Either you could put an asterisk, doctor, that says not intended for pulmonary edema or the CHF protocol or you can do that in the training. Do you want to put a thing in there that this is not for CHF.

Wirtz: You could have something written.

Olsson: So we'll put an asterisk up there that says not for CHF, see the pulmonary edema protocol, whatever. So the problem was – here it says IV drugs, you can do that, but the protocol drugs is not under the IV drug _____. That was the problem. Had this been indented, then you can do it, but it's not. What happened was in 2001 nitroglycerin drip was down here along with all of this and the vote was to move it up to the CC level. When they did that, they failed to indent that and so for the last eight years the nitroglycerin drips have been done #1 outside of the protocol and #2 without ever going to the SEMAC, so the two questions on this particular protocol is #1 to include nitroglycerin drip as an acceptable interfacility medication and #2 do we leave it at the CC and the P level or do we just leave it at the P? Dr. Fullagar?

Fullagar: I say that we go to the intent of where it was suppose to be for the last eight years.

Olsson: So if we were to take this and move it over, the nitroglycerin drip here, indent that, and now we're good. The only thing is there is a morphine drip that was included specifically, but I think if we use that form. In fact, maybe we could put down at the bottom a line that says use of the interfacility medication form is required for all medications.

(_____)

Cooney: I guess if we have an all inclusive form so that we can give ____ and __ drips and all these other potential drips at least beyond cardiovascular care, etc., then can we just add that and not worry about what drugs are covered here because if they're started at the hospital and they're coming on a drip and we're going to have our interfacility transfer with drip form then that takes a lot of the burden off of having them all listed here.

Surprenant: It was actually meant to be used with this protocol.

(_____)

Cooney: To include all drugs that we potentially want continued during interfacility transport?

Olsson: Yes. We also want to know is that for a lot of these medications that are not common, then the agency medical director has to insure that their training, that they have trained their providers all of the side effects of the nitroglycerin, the procainamide and all that other stuff that we don't normally use so that's why I wanted a specific list rather than carte blanche, and if it's not on the list then the agency medical director most likely has not trained them and therefore it's something that a field provider probably should not be doing in the back of an ambulance. Joe?

Markham: I just want to ask a simple question. Do we want to use abbreviations in this protocol that are not approved in hospitals?

Olsson: Probably not.

Markham: Like MS is not an approved abbreviation.

Olsson: I'm not sure about NTG.

Olsson: We probably use morphine, nitroglycerin, etc. that we should change that. All right, Dr. Wirtz?

Wirtz: So critical care tech can take dobutamine, but not Levophed?

Olsson: Right.

Wirtz: Should we change that? If they're going to be monitoring a pressor, why not Levophed?

Olsson: Colleen, scope of practice?

Price: Some of it – it does have to be in the CC curriculum, however, again as John was saying that curriculum is a very closed curriculum in a lot of ways so some of the newer drugs that might be appropriate for interfacility transport would be part of that curriculum and I would have to go back and look at that.

Morrissey: Let me offer, I was on the committee that created that curriculum, when it came to medications ---

(_____)

Morrissey: Well, yes, but it left the door open a new type A vasopressor came in and that's the principal, okay, that was again at the time. REMAC can set the tone and tenor for that. Remember that curriculum was created before we got into the whole scope of practice discussion where currently is ongoing at the State Council, and I don't know whether that's ying and yang, you know what I'm trying to say, which comes first or which supercedes what now, I don't know. My suggestion would be again, put it in if you want and then it gets reviewed and it can get taken out at State Council when they review it.

Olsson: The other thing, too, we've talked about as a smaller route it's one thing to run the

drug, but it's another thing to know what to do and have the capabilities of handling the situation when something goes wrong, and some of these drugs are really potent and you've really got to know what you're doing and you've got a really good handle on things, and I would be real concerned about moving some of that out of the paramedic level into the critical care level. I think that the way this is set up has served us well, and I'm a little reluctant to change it unless we have some really major good reason for doing that, and since we've got four agencies pretty much that do all this I'm not sure that we need to go through it all. Dave.

Ramsay: ____ situations, the first time I ever have had it happen, it just happened two days ago, I get a call from paramedics who are on the scene, they're at a doctor's office, they're at a facility, the doctor's office, the patient has a blood pressure of 60, there's a medication running through her PICC that they don't know they're going to stop it and take her to the hospital so because it's not in their protocol and they don't know the drug. PS, she has a cardiomyopathy, she's listed, she has an EF of 5 and it's a milrinone drip so, you know, I said run it, put dopamine in her other arm and drive quickly and she did fine, but technically I mean I don't know if we were really in protocol with that transport, but I think we did the right thing, but I don't know if we were covered doing the right thing.

Morrissey: I believe SEMAC has weighed in on this in the past and it said, it started with the sickle cell crisis, when we didn't have on-line medical control, you can follow what they're saying to get you through, if they say take a drug because that relationship now becomes between your license and that individual paramedic, as long as you're willing to sign it that ends this discussion. Unless something's happened – the last I knew – they were thinking home care and so forth, but they didn't want to

DC this stuff because it was more problematic, especially in the home setting.

Olsson: Dr. Wirtz?

Wirtz: This is just a formatting, we've got Cardizem drip, insulin drip, lidocaine drip and then below there it says IV drips.

Olsson: So this is the original writings.

Okay.

Olsson: Now do you want us to wordsmith this to make it look prettier? So if we approve the content and then we will electronically send it out after it's been wordsmithed. Okay, so we're all in favor of this content the way it is? Opposed? Carried. Okay, so these will go out for the 30 day review and comment and the next stop I think is –

Surprenant: April.

Olsson: April, here and then SEMAC.

Surprenant: End of May.

Olsson: End of May. Okay.

Surprenant: NEMESIS, the State, the SEMSCo and SEMAC have started a process of looking at the data set and carrying to the version 5 PCR, so any agency that would like, or individual that would like input into that, the SEMSCo is asking program directors to give him information and feedback on seeing what version 6 of the PCR should look like so if anybody does want to look at that and give their feedback, I do have those charts, just email me and I'd be happy to send those to you and get your feedback and roll it up into one set for comment from this region.

Olsson: One final item, actually on old business –

Morrissey: Dan, just one thing. NEMSIS will be revised this year so they're going to be changes --

Surprenant: We figure by the time the State gets to version 6, we'll have that over to State Council.

Olsson: And fortunately they're using electronic so it's already a step ahead. There was a discussion at a prior meeting on trying to upgrade how we do things and one of those was to incorporate agency medical directors into the voting position body of the REMAC. That is in its final phase, in other words, it will be voted on at the REMSCo meeting on Tuesday, and I fully expect that it will pass since it was endorsed enthusiastically at the last REMSCo. Upon completion of that vote, the agency medical directors will all be notified and will be asked to sit and participate commencing with the April REMAC meeting so unless there is something of other pressing major interest, I would like to call for an adjournment and go into Executive Session and release all of those not involved in the executive piece of this and I guess I need a motion.

Fullagar: I make a motion.

Olsson: Dr. Fullagar. Dr. Wirtz, thank you.