

Committee of the Central New York Emergency Medical Services Council, Inc.
July 16, 2009 Meeting Minutes

Name	Title	Present (X)	Status	Representation
<i>Members</i>				
Olsson, Dan	DO	X	Voting	Regional Medical Director
			Voting	Emergency Dept. Physician A Lee Memorial
DiRubbo, Mary	MD	X	Voting	Emergency Dept. Physician Auburn Memorial
Koch, Drew	MD	X	Voting	Emergency Dept. Physician Cayuga Medical Ctr.
Markham, Joseph	MD		Voting	Emergency Dept. Physician Community Gen Hospital
Wirtz, David	MD	X	Voting	Emergency Dept. Physician Cortland Memorial
Mills, James	MD		Voting	Emergency Dept. Physician Crouse Hospital
Boyle, Michael	MD	X	Voting	Emergency Dept. Physician Oswego Hospital
Whitt, Therese	MD		Voting	Emergency Dept. Physician St. Joseph's Hospital
Fullagar, Chris	MD	X	Voting	Emergency Dept. Physician SUNY Upstate Med University Hospital
Kowalski, Michael	MD		Voting	Emergency Dept. Physician VA Medical Center, Syracuse
Ambrose, Mark	RN		Non-Voting	Emergency Dept. Nurse Cayuga
Morrison, Jerome	RN, EMT-P	X	Non-Voting	Emergency Dept. Nurse Cortland
	RN		Non-Voting	Emergency Dept. Nurse Onondaga
Ramsey, Dave	RN	X	Non-Voting	Emergency Dept. Nurse Oswego
Clawson, Melissa	RN	X	Non-Voting	Emergency Dept. Nurse Tompkins
Sowles, Donna	EMT-P		Non-Voting	ALS Provider Cayuga
Merrill, Peggy	EMT-P		Non-Voting	ALS Provider Cortland
Hogue, Troy	EMT-P	X	Non-Voting	ALS Provider Onondaga
Wallis, Norm	EMT-CC	X	Non-Voting	ALS Provider Oswego
Flynn, Susan	EMT-P	X	Non-Voting	ALS Provider Tompkins
Ware, Lucy	EMT-B		Non-Voting	BLS Provider Cayuga
Butler, David	EMT-B		Non-Voting	BLS Provider Cortland
			Non-Voting	BLS Provider Onondaga
Rathbun, Joseph	EMT-B		Non-Voting	BLS Provider Oswego
Flynn, Shawn	EMT-CC	X	Non-Voting	BLS Provider Tompkins
Kushyk, Donna	PharmD		Non-Voting	Pharmacy
Lago, Ron	PhD		Non-Voting	Hospital Administration
DiGregorio, Anthony	EMT-P		Non-Voting	BLS Educator
			Non-Voting	ALS Educator
Fields, Maryann	RN		Non-Voting	Trauma Center
Loomis, Bob	EMT-B		Non-Voting	Dispatch Personnel
Darby, Warren	EMT-B		Non-Voting	REMSCo Chair
Mackey, Jennifer	MD		Non-	Pediatric Emergency Medicine Physician

			Voting	
<u>Staff</u>				
Surprenant, Susie	NREMT-P	X	Non-Voting	CNYEMS Program Executive Director
Eckstadt, Tamara			Non-Voting	CNYEMS Program Administrative Assistant
Jones, Jeff	EMT-P	X	Non-Voting	CNYEMS Clinical Consultant
Price, Colleen	EMT-P		Non-Voting	CNYEMS Clinical Consultant
<u>Guests</u>				
Jerry Joslin, Upstate				
Melissa Martin, RN ER				

Olsson: Okay, we will go ahead and call to order the July 16th, 2009 Central New York REMAC meeting. Once again, this is televised for the 3 people out there that are probably going to watch it over the next 2 years so we would ask that speak clearly into the microphone and by all means say your name or the name of the person next to you if you want to incriminate them. The microphones are fairly sensitive so they do pick up cross talk so be weary. I think what we will do for the interest of the transcription is just to go around the room so they can get a brief idea of the names, and we will start in the back with Norm.

Norm Wallis, Oswego County EMS.

Jerry?

Jerry Joslin, Upstate.

Jerry Morrison. Cortland Regional.

Susan Flynn, Tompkins County CQI.

Drew Koch, Cayuga Medical Center, Ithaca.

Melissa Martin, RN, Community emergency department.

David Wirtz, Cortland Regional.

Mary DiRubbo, Auburn Memorial Hospital.

Troy Hogue with Rural/Metro.

Dave Thompson, Rural/Metro.

_____, SUNY Upstate _____.

Chris Fullagar, University Hospital.

Dave Ramsey, Oswego Hospital.

Jeff Jones, CNY EMS.

Susie Surprenant, Central New York EMS.

Dan Olsson, Regional Medical Director. Item #1, the minutes from 04/09 were sent out electronically. I would open for any comments, criticisms, concerns, corrections. If not, I will also ask for a motion to accept said minutes. Dr. Wirtz to accept.

It's got to be a member, correct?

Olsson: Pardon me?

It's got to be a voting member?

Olsson: Yes.

Fullagar: I'll second it.

Olsson: Okay. Dr. Fullagar. All in favor?

(Ayes)

Olsson: Approved. Thank you.

Olsson: SEMAC, SEMSCo, I actually remembered to put it on this computer this time so I actually have the report. The SEMAC, if I can find it, the SEMAC SEMSCo met June 9th. Some of the

highlights. There is an organization in New York State that is named, the acronym eludes me at the moment, but they are following kids with chronic adrenal insufficiency, and a long story short is they want all the ambulances in New York State to carry Solu-Cortef with extensive training and indications for treatment of these kids going into acute adrenal crisis. That's the information that I have is that we have two of these kids within Cayuga, Onondaga and Oswego Counties. These kids are previously diagnosed. They have the medication, they have the doses, they have the syringes. Apparently there are parents who are too squeamish or whatever to give it. My response now and at the previous 3 previous SEMAC meetings has always been the same. This is under standard of care. This is assisting a patient with their medication. The State agrees – so hopefully it won't go too much further, but if you are in Cayuga County apparently there are 2 kids and EMS arrives, they can give them their Solu-Cortef IM and transport. Emergency Medical Services for Children met on March 17th and they made a recommendation forwarded to the SEMAC --

DiRubbo: Dr. Olsson.

Olsson: Yes.

DiRubbo: If the family wants to give the medicine and then refuses transport, is it just a sign-off or do they have to go if they have been assisted with giving their medicine.

Olsson: Your first premise is correct.

DiRubbo: Okay.

Olsson: The parents can give it and they can refuse transport, right. Emergency Medical Services for Children recommended that the SEMAC pass an advisory that states that protocols be carried on each ambulance. Nassau County has taken it upon themselves to self-direct ambulances for EMS hospitals that don't go on diversion, that are clearly overcrowded. EMS will redirect their own ambulances without the hospital's input. Ketamine has been added to the State Formulary. There was a fairly good discussion about that. There will be further information about formal use, outlines and

what not coming down the pike. State-wide guidelines, there is an effort underway to come up with some form of State-wide ALS advisories. The State cannot issue protocols. Interestingly enough there are at least 3 groups of individuals working totally independently to come up with 1 State-wide ALS guideline which is somewhat ironic if you think about it. So more to come. Blood transport, the committee from the State is looking into it, is in the rough draft stage of the forms and circuit patients needed, there is no approval on that yet. Epi-pens on BLS ambulance is not as yet a State-wide development at least in the New York City area, but they're working on that. There has been a question on who can provide on-line medical control. There is a big discussion and debate that has been going on the last 2 SEMAC meetings, does it have to be a physician, can it be a physician extender, can it be a level 4 paramedic, can it be a this, can it be a that. The SEMAC and Medical Standards is developing a subcommittee to look into it so more to come. The chest pain centers, the Cardiac Advisory Council this summer is going through their final review to set up the rough operating guidelines. They don't even have a name as to what the cardiac centers will be called. So we've got a ways. There was a discussion about core content, indication being allowed up to 100% for on-line CME, currently it is 50% or less, and there is a discussion about how that would work, whether it would be interactive, recorded, etc., etc., and again no clear answer yet. Let's see here. Lee Burns, for those of you that know her, was unbeknownst to her promoted to Operations Management something or other. Let's see here. Not all ambulances in New York State carry AEDs or the equivalent. SEMSCo recommended that AEDs in Part 800 carry them, go figure. There was a brief discussion that was tabled and referred back to the Safety Committee touching on what procedures should or should not be done unbelted in the back of a moving ambulance. Finally, the Legislature placed a sales tax on transportation services, and there was apparently a discussion somewhere at the State level that says ambulances are transportation services, do they fall under that, and the answer is no, they are not subject to that tax. That is the gist of SEMAC SEMSCO for June. Air Medical did not meet today, will meet again in

October. I'll turn it over to Susie for CQI, Program Agency and other assorted bits of interest.

Surprenant: For CQI for Oswego County, we had one case that we were looking at, it was a cardiac arrest where capnography was not used. In this region since January 1, it is used for all intubated patients so the provider as of now has been reminded that that is part of our procedure. Come September 1st when we have the protocol release, that will be part of the protocols so that will be a protocol violation for providers. Cayuga County has been quiet. Onondaga County has several cases going on. One involving a controlled substance medication error, also there was some documentation issues, falsifications, how it was referred to the State and also another medication error so we're looking at that. With Tompkins County, it has been quiet. Cortland, there was medication error with the use of amiodarone. So those have all been reviewed by Executive CQI as well as a report given to the Regional CQI. For the office report, in the new business, going material release for the protocol roll-out, so we will be reviewing that information and what each provider is going to be going through in the next couple of months before the protocols go live September 1st. The other thing that we were busy doing is with the new scenario-based CME process, we trained approximately 130 CME evaluators for this whole region, and June 30th ended the first semester, so that was the first semester where we used the new scenarios and the new skill sheets and then also for _____ going through the second half. So I perceive in January we will have some feedback on that new process, but one of the reasons for the change is we've had previous discussions was for some of the CQI issues that we have seen that are repetitive _____ issues so we developed more scenarios based on some of those to try to be more proactive with the issues that we are seeing. So we've been busy with evaluator courses and protocol roll-outs. We did hold 12 classes and trained 90 providers, train the trainer, and those providers are going back and going through the material that I will be showing you later before the protocol roll-outs so they've got two months to do that by September 1st.

Olsson: Any questions for Susie? Thank you. New York State requires that we read into the

record individuals that have been suspended, penalized, etc. John Kochay, from Marlboro, New York, 10 violations of Part 800, suspended, civil penalty \$2,000, David Forester, Dansville, New York, similar violations, 1 year suspension, 3 year probation and \$1500 penalty, Atlantic Steamer Fire Company #1, Oyster Bay, New York, violations of Article XXX, civil penalty \$2,000, Darnell Hagins, New York, failure to comply with previous stipulation order, suspended effective 06/01/09, Douglas Recupero, Great Neck, New York, part 800, suspended 1 year, suspension was stayed, probation for 3 years, civil penalty \$2,000. Old Business. First we will look at the minimal equipment list.

Surprenant: The minimum equipment list, back in January we reviewed and approved that for transporting services and back in April we had the one for the first response. There is a first page to that policy statement that we just need to make some minor changes to it before we approve that policy statement. As soon as the computer warms up. While Jeff is pulling up that documentation for minimal equipment. New Haven Fire Department had requested at a previous meeting to go from level 3 first response service to a paramedic service. They have the providers. They also have a medical director and what needed to happen was on-site inspection, and I inspected 2 of their vehicles. They have passed inspection so we just need a vote for REMAC to approve them to be a paramedic FR and they're in Oswego County and one of the things for them to go FR was the fact with capnography and the fact that there is now only 1 hospital in that area they didn't know if there was going to be a delayed transport time so they opted, since they have the staff, to go to the paramedic service so I think that is in addition to that county. We need to vote on that. We just need to vote to go to paramedic.

Olsson: So all in favor of the upgrade for New Haven? Opposed? Passed.

Surprenant: The minimal equipment, what it states is, it says ALS, ALS FR, but if we look at the charts that we were looking at actually it was for ILS services as well as the CC and paramedic services so we really need to refurbish and include ILS in there as well. The sections in black that refer to

Part 800 have remained the same, and there was section – because this policy was originally designed I think in 1997, but it also listed some radiofrequencies that were specific. When we reviewed those, a lot of them were not specific to just this county where we are a five county region. So Dr. Olsson and I looked at that to say can we make it a little bit more generic and say part of the State competency, a way to communicate with the hospital and then leave it up to the agency to decide what else is going _____ vehicles and communication. So it was very specific to what channel, how many channels, but I think the key is do you have communication to not only your 911 center or your dispatch center, and also to the hospital. So that was those changes. And then we had to change the pediatric measuring devices, we had Broselow there and as we know in the protocols, that is a trademark name. The SEMAC had us change Broselow to pediatric measuring device. And then in there from facilitated, it didn't address the capnography, it only had SPO2 so we have added that so it is consistent with the protocols, and then was a chart for transporting for minimum equipment that was approved already by this committee as well as FR. So this is the last piece of that policy statement and then it will be updated.

Olsson: Any questions on the changes in this document? Norm?

Wallis: Just one question, Dr. Olsson. Norm Wallis from Oswego County. In previous policy statement by Central New York EMS, I thought that it was recommended that they have VHF, it wasn't mandatory I thought. And now we're saying in this document that all agencies have VHF capability.

Olsson: I will defer to – I think – the 155, 340 isn't that VHF?

Wallis: It is, but in previous policy statements it was recommended, it wasn't mandatory.

Olsson: Right, but if you're going to have 155 340 you have to have VHF, right?

Wallis: I understand, it was optional before. You didn't have to have it.

Olsson: Right, but I think that the intent was so that everybody would have access to the State-wide frequency. Do you guys have that?

Wallis: We do now, but when I went with SOVAC that's why I say that, in the policy statement it was recommended that and it was pointed out to me that it was recommended. Since then we have switched to 155 340, but it wasn't mandatory. That's all my question is.

Olsson: Right, excuse me, I have no problem leaving it as recommended. My concern would be the agency that looks at that and says well it is recommended so we don't have to have State-wide frequency so now you have an agency who unlike everybody else nobody can talk to. I don't know how realistic that is, maybe it's not so I'll throw it out. Do you want to leave it as recommended or change it to "have"?

Wallis: Or at least make the two documents equal, you know, if we could have Susie investigate it just to ensure that there hasn't been a policy change since I looked at it, you know, just so that they will say that they need to have it, that's fine, too, I mean I'm just saying you've got two documents with conflicting verbiage.

DiRubbo: Well, that's what it says. This is a new – because it says deleted. It is recommended, which was voted as previously stated, so that the new policy is saying that it is required so previously what you're looking, if that is what you're saying, it is deleted out. It is recommended, we are now stating that it was required. We want to make sure that nobody falls through the loopholes, and I think that we should state that it was required because we don't want anybody who does not have the ability to speak with the State so that I would leave it as required.

Olsson: That was intent of the State-wide frequency and why would you not have it.

Wallis: I guess I was just – the only reason I'm bringing it up, Dr. Olsson, so that someone could have a misinterpretation between the two documents. I don't know if that makes sense.

Olsson: Between which two documents?

Wallis: Central New York's policy statement, now this minimal requirement.

Olsson: Okay –

Surprenant: This is the policy statement.

Olsson: This is the policy statement. If you scroll up – oh, you know what it's not on this one.

Surprenant: The policy statement on minimal equipment this is where this is from, this is the first page of it, but if we look at the minimal equipment list, the policy statement actually applies to the ILS and ALS agencies, there are approximately 55 of those agencies within this region. We've got a total of approximately 175 areas in the region. The others are BLS so this policy statement only applies to our ALS services and our ILS services, both FRs and transporting. I'm trying to think what policy statement, Norm, that you were looking at.

Wallis: It was a previous Central New York EMS policy statement in regards to communications.

Surprenant: This was communications.

DiRubbo: Maybe if you can send that to Susie at the next meeting so we're uniform, if we state that this is going to be required Susie can look to see if we have another policy statement that says recommended so they're both there.

Surprenant: What I can do if you want to continue with this and come back to this, I can look for a policy statement while we're having this meeting and bring these back and see if we can find it. Communications.

Olsson: So these are all the policy statements.

Surprenant: Norm, do you think it was on dispatch maybe?

Wallis: I can't remember, Susie. It has been a long time since I've looked at it.

Olsson: Pull up minimum equipment which, is that one we're talking about, on 19?

Surprenant: Okay, this is the page that we're looking at now.

Olsson: Right, this is the original text of the policy statement.

Wallis: Right. On that, continuing down, it says it is recommended that all the agencies have VF, it does not say it is required, it says recommended, that's what I'm saying.

Olsson: Correct. So the discussion point is, is it recommended or do we say you've got to have it. That's the gist of the question.

Wallis: Like my own personal perspective is, I think it should be a requirement. I just want the two documents to match so there is no miscommunication.

Olsson: It's only one document.

Wallis: Okay, but the old one says this is a minimal requirement list, this one says recommended.

Surprenant: Okay, this is the top part of the minimum equipment list so, Jeff, if you scroll down --

So what you're voting on will supersede that.

Surprenant: Correct.

Will replace that.

Correct.

Okay.

Olsson: All I did was I took the text out to edit it because it was in the _____

Wallis: Okay.

Olsson: The same document.

So yes, this is the first page --

If you go to the track change.

Olsson: All right, any further discussion?

_____ do you really want to mandate that?

Olsson: That they radios that they can talk on the State frequency?

Yes, to make sure they all do that. 155 3 40 has been a national standard since 1970 something for ambulances to talk to hospitals.

DiRubbo: In every day use, we're not necessarily going to use, but when we have a disaster, now we know all the ambulances have this radio and they have this frequency and we can talk. It may not come into play at all, but when you're trying to deal with a mass casualty situation or some type of disaster it would be nice to know that they all this have this radio that is required and it's there. So I would say yes we want it required. Even though people on a day to day basis say I never use it. I use my cell phone now and I call into the ER.

Olsson: Jerry?

Morrison: Jerry Morrison. Do we have any ability with BLS agencies because Part 800 goes through, identifies that we have to have telecommunication capabilities with hospitals, specifically does not identify any frequencies. (_____) every bit as important, maybe even more important for the BLS agencies, especially those that are intercepting the ALS agencies to have that communication.

Olsson: I don't think we do, but that is certainly something we should -- we can put on, to look at between now and the next meeting and see what there is and what we have. Everybody in this room knows that _____ you don't do, communication is the most significant thing that we do do.

Morrison: And just so you know, also, currently there will be an issue in Cortland County as a result of it not being a mandated frequency by the State, I

believe that Cortland County's license is hired _____, there's a base station that is out of service so as they would not issue the license to the hospital in the absence of a mandate from someone, a regulatory agency saying that we had to have the capability _____. So we're going to have a Cortland County issue, and I agree, we need to have the ability to talk to everyone, whether it's mass casualty frequency or this one, there will be an issue in Cortland County currently..

I just _____ clarification. Am I reading that right, we drop the requirement for _____?

I think the original documents _____.

The original document in it had a statement that was requiring telemetry?

Olsson: Right.

So we're just going to drop that?

Surprenant: In the 2 minimal equipment lists that you already approved it is listed in there as telemetry and it was -- without looking at it -- ILS, CC and P.

Okay.

Olsson: What we took out of this policy statement was the reference to having cell phones with telemetry capability.

Okay.

Olsson: The 12 lead is going to develop, I think, into its own being so it speak and I don't know if it is still going to be referred to as telemetry, it will probably end up with some other name attached to it. I think most of us would associate telemetry with -- for those of that remember the old orange boxes, that was telemetry so. Okay, anything else? All in favor of the protocol changes as listed raise your hand. All those opposed? Okay, passed. All right, okay, medical direction. Tell me I didn't put it up there.

Jeff: You didn't put it up there.

Olsson: I asked you not to tell me that. 09, yes, okay.

Surprenant: This document was handed out, Jeff, scroll to the top. This is suppose to supersede the policy statement 97-04, in April we handed this document out with the changes for this review before it was decided on and voted on. So the sections in highlight are the same sections that were changed back in April.

Olsson: Can you go down just a little more, Jeff. Okay. So take a look at that and once again this was discussed previously and brought back for final review, discussion and approval.

The stuff that is outlined in the dark there, does that mean that it has been taken out or is that just another form of highlighting.

Olsson: That is an additional change that was made. We made 2 sets of changes I think, and that's just denoting the second change. Can you change that to yellow?

DiRubbo: Can you scroll to the top? I don't see anything wrong with the policy other than maybe we should try this fall to comply a list of the physicians who are providing the on-line medical control. So at my facility it has been a while since we have had some turn-over, policy statement as well, but followup it with _____ hospitals, should be providing on-line control.

Olsson: New Business, part B. Okay. Seeing that _____, any more questions, comments, concerns about 97-04 soon to be 09-04. All in favor of 97-04 becoming 09-04 as written raise your hands. Opposed. Okay, thank you. We've had a few instances of patients ending up at hospitals where maybe they didn't want to be. I don't know how much that occurs in Cayuga County and in Cortland. We talked about in the past what constitutes demand. The State says that a patient can demand to somewheres. If the patient has a family member who says take them to hospital whatever, is that a demand? If they have a discharge medication list from a hospital from 2 days ago, does that constitute a demand. I think this is something that we need to look at, have some

kind of an idea or consensus or outright disagreement on. So I would look at input from the physicians and the providers, I mean. It's in the patient's best interest I think to go where they belong. It doesn't do anybody any good to electronically shlep records from point A to point B and if we as a group can come up with a well-defined list of what constitutes demand we can send that to the hospital executive council and the CEOs of the hospitals and they can do with it as they see fit. So I will open the floor up for anybody. Dr. DiRubbo.

DiRubbo: In Cayuga County, we face this all the time. Versus going into Onondaga County than coming to the local hospital. What I've always been told that there is 2 sets of arguments here. On a State level, the patient demand is where the patient wants to go is where EMS would transport them. On the Federal level, Medicare and Medicaid laws, says they go to the nearest appropriate facility and so the EMS providers in our county know that Federal law trumps State law and a patient per se coming out of Auburn wants to go to the VA they go to the closest facility, they come to Auburn Hospital and then the need is met to see where they transfer because the Federal law, Medicare and Medicaid guidelines state that they go to the nearest facility, not by patient choice.

Wallis: Dr. DiRubbo, let me add into this, that the New York State EMS protocols also state, closest appropriate facility. So in effect you have got the Federal statute as well as a State EMS statute. They both say the same thing. There are a lot of issues that are going on with this, and from a reimbursement standpoint from pre-hospital, what is -- the insurers are really putting the squeeze on providers to take them to the closest appropriate facility. They're getting to the point now because there's been another change in the proverbial paperwork so it's getting more difficult so I think what may happen is that the patients are going to go to the closest appropriate facility unless it is dictated by trauma, stroke, maybe some day a STEMI protocol or something of that nature.

Olsson: Specialty hospitals notwithstanding.

_____ : A couple of things, the Federal guidelines are reimbursement, and they don't care whether it's a trauma, STEMI, what your local protocols are. They really don't recognize that so you could say that you've got to take them to the nearest trauma center, it happens in Auburn, you can only bill to Auburn Memorial Hospital, you cannot bill, it doesn't mean you can pay, but you can't bill for that, unless you can demonstrate that a significant proportion of the patients who were seen in the hospital in Syracuse come from that zip code so what you have to do if you want to bill for a transport from Auburn is to look at the zip codes of admitted patients to the Syracuse hospitals and then you can say that this is actually a single community, the patients routinely leave Auburn to come to Syracuse and it's viewed as a pseudo-community and then you can transport to any hospital within the community and bill for that mileage, but it's a billing issue, it's not a Federal regulation that says that you have got to take them to the nearest closest facility.

Wallis: Dr. Olsson, let me add one other thing with the billing issue. If we bypass a closest, a closer facility, they're not only rejecting the mileage now, they're rejecting the entire bill which now we have go and justify the – for example, pick up somebody in Auburn, we transport them to Syracuse, there's 27 miles difference. They are at this point not paying us for the 1 mile to Auburn Memorial or _____. That's a very recent within the last 2 weeks this has started to occur.

_____ because that's not the way the law is written, that is not the way most people apply it. But you have that ability to demonstrate that Auburn and Syracuse are essentially one medical community in which case we can transport to any medical facility in that medical community. In order to do that, is demonstrate that the people in Auburn routinely get their care in Syracuse.

DiRubbo: My point has to do, too, not how we word this statement because, when it comes to the patients coming in and we have demand issues, and the people in this room, are complex, and understand what's behind the scenes, a lot of my nurses don't, the families don't, and when you say EMS personnel won't go to the facility unless the

patient demands, but that really doesn't give them the ability to demand to go to the VA because we need to be careful how we word the demand, saying that we're going to let the patient go by demand in our policies because then I get people saying, well, you violated the policy. The patient wanted to go to the VA, and the ambulance service brought them here. Isn't that a violation of Central New York policy?

Olsson: And that's why we're here. I mean --

_____ : So an ambulance service can set reasonable limits on their transports and they need to create their own policy to set those limits. If an ambulance service creates a limit and says we will only transport to this facility from our area unless it's a major trauma or whatever the circumstances, they can set those limits.

DiRubbo: And we've gone with that. When we go to a lot of the volunteer ambulances, we do make that statement. They don't routinely transport to Syracuse, either they hook up with another agency or they bring them to Auburn first and that's their hospital regardless of what the patient's issues are. However, we do – because we have the trauma center, the stroke center, and now identify patients who are going to cath lab we send them to Syracuse so they can get the cath first because it is more of an issue because we do have several ambulance services that will bring specialty patients to the Syracuse area and it gets confusing and it often causes bad feelings for the ER personnel and the EMS personnel when a patient shows up at my door demanding to go to one hospital and being here and nobody quite understanding why they're here when they clearly stated they wanted to go somewhere else.

Olsson: So this is the State policy and –

Wasn't there a letter in 1999 from the Commissioner of Health basically stating that diversion is not permissible in New York State?

Olsson: There may have been, but there is also – I probably can't find it, it's either in this one or in a similar advisory that they very stealthily tip toed around diversion, closure, demand.

That was a letter from the Commissioner of Health. If you're an administrator of a hospital, a CEO --

Olsson: Then I don't know what that is.

It said that diversion is not an acceptable behavior, and you will not divert so – the larger question is should we recognize diversion as EMS as providers of EMS services, should we even recognize diversion since it doesn't do anything good for the system.

DiRubbo: I think we have to recognize it because our providers are faced with it on the street. I mean ideally if we could talk to the uppers in the hospitals and get the hospitals not to go on diversion that would be what we would want, but since we know that the Onondaga hospitals do go on diversion we have to recognize it and provide something for those people who go in as EMS providers of how to handle it. Because we can say that we don't believe in diversion, but the men and women out on the street are going to be faced with a certain hospital on diversion and well, what do I do.

If we tell them, ignore it, it doesn't matter to us, it's not something that we recognize and we won't allow it in ____ and it's not their problem.

DiRubbo: Then every one in Onondaga hospitals really need to go back and educate ERs. Because I wouldn't want to be the paramedic showing up on a hospital that's on diversion with a critical patient in there because I know that they are going to act. So I don't think that we should --

Olsson: It would behoove us as a group for diversion to go away. I don't think there is any debate on that topic. However, the difficulty becomes from the fact that the REMAC helped create it at the request of the hospital association, not that that doesn't mean we can't do away with it. The difficulty would be that we would be asked to realize shooting ourselves in the foot, somehow we have to convince the hospitals that they need to divert. Part of that could be taking patients to the hospitals that they want to go to. I don't know, maybe we can't define it any better.

One of the possibilities is diversion is a very on-off, you're either on diversion or you're off diversion and it may be that if we had some information, if more information was shared, we could give patients real information. One of the things that concerns me working at St. Joe's is we have two neurosurgeons so we have uncovered days. It would make sense to put something out that says there is no neurosurgery coverage available so that a possible head bleed does not come there.

Olsson: That was brought up a couple of times over the last several years and conversations with Mr. Lagoe, no hospital is willing to go out and say here's what we don't have.

I think that as an EMS system then we can give them the option. If they want to provide us with information, we may consider that information in determining patient destination. If the information is not going to be forthcoming, then we simply don't have enough information, diversion is not sufficient information to appropriately determine patient destination and therefore, we simply aren't going to pay attention to it.

Olsson: Well, by having the patient say take me to Crouse when they're on diversion, that in effect is not paying attention to it. So the gist of this question was if the patient can't say that, who can, not whether or not demand diversion exists is good or bad, but in the cases where the patient doesn't know or is confused who can make that demand for them. Can it be the health care proxy, can it be a family member, can it be the doctor? Not whether it's a Medicare issue or a transport issue. It's going to be a question somewhere along the line what hospital do you want to go to. Okay, they're closed, okay, take me there, who can say that, that's the question that's before us. Dr. DiRubbo.

DiRubbo: Can we then – just to narrow the scope, where it says patient demand, can we put for hospitals on diversion. Because if you put this out, patient demand – because it's going to come back to me, and it's going to bring up a whole bunch of other things of patient demand in general. See this policy states that the patient can demand to go to a hospital and just the whole thing, patient demand

while on diversion, it eliminates what I've been talking about already and just leaves it to –

Olsson: Let me just tweak something here real quick. I did this – this is one of those things I did because I knew that I was doing it. So this is actually the subheading under patient demand. So transport to hospital on diversion . . . and then it's, okay, what constitutes patient demand. It is when –

Any time.

Olsson: If the patient is unconscious and the family says take him to – and they do that. Because right now technically they can't.

You just started to say what I was going to ask about. I think the question that you're asking really has nothing to do with demand _____.

Olsson: Requests, hospital requests.

Who can request the hospital? Whether they're on diversion or are not, who can make a choice on patient destination. So really I would get rid of the whole demand piece in this part of the conversation.

Olsson: This is the excerpt from the policy statement.

I'm just thinking for clarity what we're talking about is a much larger question than just demand. It is who has the right to –

DiRubbo: Decision.

To make a decision on patient destination. A, the patient, B, the family _____, health care proxy if we honor that in terms of destination, etc.

Olsson: Right. Can you type out, instead of demand on that second one and just type in destination?

It has nothing to do with –

Olsson: Whether there's demand or not.

Wallis: We're addressing two issues. One is we're saying who has the right to make a decision for a

patient that isn't able to make a decision on their own, okay, so that list is fine. That takes care of problem #1 and that is where do we take the patient and who can make that request for that patient, okay, so that's an easy fix. Going back to the diversion issue, and this is kind of philosophical opinion and that is that when all hell breaks loose, EMS, what do they do. We find more ambulances somewhere, but we continue to step up and answer the calls and it doesn't matter what community it is. The hospitals don't see doing that. As a medical community, we have responsibility to the communities we serve, and a hospital going on diversion is in effect saying, oh, we don't want to serve you, community, at this point because we're understaffed. The list is long and impressive. The bottom line of it is that the executives of the hospitals need to step up and fix this problem. It's not an EMS problem. It's not an emergency department problem. It's a system problem, and it's going to begin with the executives of the hospitals to say, all right, we're going to stop playing this procedures pay game, okay, there are hospitals that I've stood in where an emergency patient from the street, and I've watched 3 or 4 interfacility transfers go by to the floor. That emergency room physician is ripping his hair out because he needs a couple of monitored beds to keep things moving. He can't get them because they're saving those beds for those procedures. So the responsibility of diversion lays right on the executives, and they're the ones that need to step up and fix it.

DiRubbo: I think to go along ____ if we're going to get rid of diversion, the way to do it is say that we do not recognize diversion, what we recognize is internal disasters and make the hospitals, instead of going on diversion, go on internal disasters because that now -- when it's diversion, it seems to be the ER. It's the ER physicians, the nurses, the ER needs to do it. Once you get into and you have declared an internal disaster, it's no longer the ER, it's the executives, it's other people in that hospital having to mobilize. So if you were going to go to where we didn't want to recognize diversion, I would say that we wouldn't recognize – what we would recognize is internal disaster. It gives an opportunity for a hospital that is really overtaxed for whatever reason to divert EMS away, but they've already got policies and procedures set up for internal disaster

that they may not want to turn on as quickly as they turn on the fact that telling the ER director go ahead, put us on diversion.

I would agree, there is a certain point on which a hospital needs to be able to turn off the flow and the internal disaster criteria is probably one of the better ones because most hospitals do require fairly high level authority before they declare that. I do worry that that will become the _____ the hospitals will figure out well, we can just change our internal disaster policy. I think though what we have to do is we have to work on this and basically long term we have to tell the hospital, give the hospitals a deadline, a date certain, and say we will not recognize diversion after this date because it doesn't work. The literature is pretty clear it doesn't work, it does bad things to the patients, it doesn't help the system. The other piece though that is going to have to go with this is we need to create a policy that says that we cannot, they need to be on notice that we cannot provide care for these patients in the emergency department, that our providers once they cross the threshold are not providers, and that's one of the things that the hospitals do not understand, is that a paramedic when he walks across the threshold is nada and can't provide care, and the hospitals as part of this whole discussion need to really understand that they are going to have to provide nurses to care for those patients, they can't leave them on hospital stretchers and have paramedics care for them, that's against the law.

Olsson: Actually what happens is because of the fact that – let's see if I can find it real quick – there is a place down state where a 3 hour turn-around time is not uncommon for EMS in the ED.

Wallis: Rochester has been reporting 2 hours, Strong.

Olsson: What the DOH has said is that you are able to provide the medical care that is needed for the patient even when you're _____ which contradicts some of their other policies.

So paramedics are allowed to provide patient care in an emergency department at this time.

Olsson: When they have a patient with chest pain, diabetes, whatever, who needs a blood sugar, who needs a nitro, oxygen, yes, they can give it, according to them, according to DOH. I think it was the meeting in February that I don't have on here. Okay, I will word smith something and get it out electronically prior to the next meeting, but I would like to move on, okay, here.

Surprenant: _____ a list of agencies that I've submitted the paperwork since the last meeting. We've got Weedsport Fire Department, Minoa Ambulance, Mattydale Fire Department, EAVES and Trumansburg. We said at our previous meeting that as long as they're complete we will just give continuous updates at each meeting for you guys. The protocol roll-out, these packets were handed out in the Regional CQI and then for REMAC physicians, Tammy did mail your packets out, but in there, in there is documentation that each of the providers are receiving and that agencies receive. What we've done is done 12 train-the-trainer roll-outs and trained 90 providers who are going back to their agencies to train the other 600 that remain in our region. The protocol DVD includes a 60 slide set with verbiage and voice clips on each side that explains how each protocol has changed and exactly what the protocol looks like in the book, with highlights of where it changed. Dr. Olsson did the 4 protocol pieces on the new skills so that's included. So they are going to sit in an approximately 4 hour session and going over the packet materials as well as the skills. We submitted a pediatric seizure quiz in there based on the current protocols. _____ cleaned up with the current protocol and from the variables that we have, we could come up 18 different ways that protocol could have been administered and 3 of those were all in writing. We did this just to show people how many variables and actually the things that we have seen and as we see it, it was very confusing and people have not selected the current. The other thing that they've got in the packet that shows all of the slide set so that they have that in their records as well We are providing DVDs to people if they want their own personal use for later. And we also have all these documents on the web site as well. There is a checklist for the trainers so they know exactly what they're going to need equipment wise, material wise for the class. We've put a summary sheet in here

and also told the hospital staff that they could put that up at the hospitals because it shows ___ALS changes, new protocols, medications, the new skills. Also, we provided several protocols ACLS, asystole, PEA, hypothermia, altered mental status and also we have listed the new skills and there is a nice checklist on the bottom of it of the things that have been added to the protocols as well as to the _____. They've got medication sheets on new medications that Dr. Olsson did, and we included the policy statements on fentanyl, RSI and _____ IM, and there's the skill sheets. So all of this is happening and it's going to take them approximately 4 hours to get through the training. The other training that we did back for 05, 06, and 08 protocol updates. We didn't do a lot of the changes in there. Looking at how many changes and how many pages got changed in this protocol book, you really need to sift through and make sure that you get through the protocols and the standard material. Once they're done, there is an on-line test for both the skills as well as the didactic. So that's out. That will be going to each _____, I know Tammy had some in the mail, and each of the providers are getting those as well.

Olsson: So as far as the physicians go, what we're hoping to do in the next week or so, we'll send out to the ED directors a very similar packet and what it's going to contain is the spinal immobilization protocol, the base station course, and the intubation study form that is new business. Our intent is to then have the ED directors supply us with all the physicians that are currently working in their departments and probably with their State license numbers, that will allow us to, for example, take the last 4 digits, create an identification number and that way we can track which physicians in the region have completed the protocol update, which have done the base station course because there has been a substantial turnover in the last 5 to 10 years. We have not had a significant approach in tracking physicians participation with base station courses and such. That's our intent. Hopefully that will come out in the next week or so. With regards to RSI, it is in the protocols. It is not part of the protocol update for the simple reason that we're not ready to implement it. It was passed by the State as part of our protocol package. Those of you that have been around long enough, this has been an 18

month project. For us to add something 6 months or a year from now, add another 6 months onto the whole grand scheme of things. We have the protocol. We have a 7 page policy statement that says the following can be done. I think it's very important that we have a very thorough training, remediation, etc., a very strong package before we implement it so that's why it's not part of this roll-out. The spinal immobilization, for those of you that are aware, that's a BLS skill. It's required and mandated to be completed, the training by December 31st of 2008. The regions were then to their own devices on how to implement it and my feeling was that once we had everybody trained we would implement it. Needless to say, we have not implemented it, we do not have everybody trained. Discussion this afternoon at regional, Troy brought up the very point that as long as the transporting agencies, since they're going to be the default, and agencies that are going to be ultimately responsible are trained, then once we reach 100% of those, then I think it is reasonable to go ahead and implement it. So we will look at that and as soon as that number is reached and people are trained, we will put it out there, but we will include it in the physician update package.

Dan, do we have any idea what the time frame is going to be for those folks to get trained. Because, you know, you've got people who were trained by, you know, by late last year, and we're not going to get into this until 2011 because some people are slow, we're going to need a whole other phase, what have you.

Olsson: We will have to recommend that they have a review with those that have actually stepped up and done what they are suppose to do, that it would be in their best interest to review it. I think – in going through the 60 slides, something like, the first time, the second time through really should be fairly quick. So it's definitely worthwhile updating those individuals.

Wouldn't it make sense though to set a time, set a date that these folks either do it or they just – they're in default of some sort.

Olsson: Well, that was part of the discussion earlier, too, what is the default. The default has been

that nobody does it. And it didn't seem to bother a lot of people. So I don't know what we could take away, but I think Troy's point – the transporting agencies are the ultimate ones that are going to be responsible one way or the other. We get those people trained and most of those are. It is the non-transport agencies that are actually – so what we'll do is we will send to the State those who have not completed and then see where the State wants to go, but at least if we get the transporting agencies, then we could get it up and running so that will be – Okay, that's all I have on that. Do you want to talk about –

Surprenant: This is actually a report that we did, developed almost 3 years ago now, and it was developed because we looked at – at the time the State had a BLS FR form, BLS agencies as well as the PCR, but one of the things with the PCR it only allowed an EMT or higher to fill it out. It didn't take into account that a lot of the BLS FR agencies out there and the CFRs, a form was developed, the State has looked at this and actually liked what they saw and made some recommendations and we changed them to a final product, but the thing with this is the money to produce a form like this for agencies that did not want to use a BLS FR form. Since then the State has stopped producing the BLS FR form and said everybody has got to fill out a PCR, but they still have not changed their PCR form so we have agencies, we have had five agencies that used to be BLS FR that are now considered industrial sites that have AEDs that we service, but technically we don't have any documentation to document patient care on. I have no problem saying okay, we've got a form, to give it out and they can make copies of it. We've had some discussions. We've got Shawn Quinn from the Ithaca Fire Department here and we discussed is there another form that the BLS FR agencies can use. And I said, well, we've got this form sitting there that we can resurrect, say do we finally approve it with some changes so that BLS FR agencies do have the option to do something other than the State's PCR form. The caveat is that we don't have the funds to produce something, but if an agency wants to use this, and be able to provide the transporting agency with a copy, whether it's a duplicated form or you've got a miniature copier in the back of your first response vehicle you can do it.

(_____)

Surprenant: So looking at the form, the things that would have to change is take out for CFR, noncertified, because this would be for any BLS FR agency which means a CFR or higher to fill this out. So CFRs they don't do the complete vital signs so for an EMT we would have to include that section and include the complete set of vitals and actually just on the bottom include EMT if they are crew member filling it out. The rest of it was pretty clean cut, tried to make it look like a PCR and BLS FR before that. So before we change that we wanted input from REMAC because before we make any form changes we have to get this group's approval as well as the State's approval. Do you feel that this is worthwhile and worth the effort to change it so industrial sites, the BLS FR agencies that do want to produce this form have that option?

I would suggest that each agency develop their own form. I have several first responder agencies, and I get very poorly filled out forms. Maybe one or two words, it's just not there, and they sign it and then they think that they're done, and I think maybe it would be better so that it's detailed to who the people are and what information they feel are important to deliver, for each agency to do it, then us to put out, because I can tell you from my first responders I get like transferred to TLC, signed on the bottom, and they just want to get the paperwork done, that's what ends up coming with it so I think that if you make a beautiful form and it's just not going to be utilized and it's better that the pressure comes from the individual agencies to complete the forms that they want to have completed.

Surprenant: The other thing with that is any time we used a form other than the State's forms we have to get their approval. So if we had say 15 agencies that wanted to use different forms, all 15 of those forms would have to get approved at this level and then on the State level.

Like Welch-Allyn who has a medic there. They have their own form they fill out and they just copy it and give it to me.

Surprenant: And they're an industrial site so the State does not consider them a BLS FR agency.

So it's either this form or no form?

Surprenant: Or fill a PCR out. I mean – all BLS FR agencies right now, the only option they have is the PCR. Shawn, if you want to –

Flynn: I think what we continue – we can continue to use PCRs. I can pretty much guarantee we will not be going electronic unless you mandate it and then we'll have to ____, but as far as anything else, we're just trying to provide, you know, the same level of care, at least continuity of care as to what was done so that when the patient reaches the emergency room the first responder, the first one there that provided care, there is documentation. We will continue to use PCRs. I just didn't know if you wanted to because there are 3 parts now, if you want to save ____ whatever, it's up to actually anybody, I will keep going the way we're going and use PCRs. I just thought that if there was another form we wouldn't go the expense of the PCRs.

I think _____ sparsely filled out PCR forms.

Flynn: If you want to change it, I don't have a problem with it. We will stay with the PCRs. I just thought adding on because Susie and I had talked about EPCRs and everything else, where this is all headed toward and so I said if there is a change down the road with forms, you know, if there is something that we can look at and Susie said that they were looking or she was looking at, so I says is that for us or not.

Surprenant: What we will do is keep it in the wings again because one of the things that the State has to do is become NEMESIS compliant and they're not capturing any -- close to any of the public data points they should so the PCR we see today is going to change drastically when they do that. They've already said that it's probably going to be a 2 to 3 page document versus 1. So that may force them to do something ____FRs and if we come up with a 3 part form, I think our 1 part form we will have it ready.

Wallis: Would it be feasible to propose this to REMAC for approval and then those agencies that would like to buy onto this type of a thing and leave it up to them. If they would like to certainly develop their own form such as Dr. DiRubbo has suggested, then they could certainly do that as well, but then this form would be already be approved by this REMAC. I don't know if that makes sense.

Olsson: Well, we could certainly approve an alternative form.

DiRubbo: I think the biggest thing is that if it's only one piece of paper that's where the problem is because you're not going to have the electronic means to copy it on scene. So what do you do with the one piece of paper. You can't give it to the transferring agency because you'll never see it and you don't have it on your own agency, if it was like a PCR and it was several copies, then I think everybody would be going go ahead and approve it, but if it's just a one piece of paper form, that's what poses the biggest problem.

Surprenant: And that was one of the reasons it has been sitting there because we don't have the funds to produce another document like that.

Flynn: Can I make a suggestion, just hearing and thinking? For the first responders that can't fill out the PCR because it's a State form and they aren't allowed to write on it or something. I would say go ahead and say go ahead and approve this form the way it is, don't change it to basic EMT and let the basic EMT people still fill out the PCR until the State changes, that would be my suggestion.

Olsson: Even if we approve it, we're not mandating its use.

Right.

It's an option --

It's an option.

--available.

Flynn: It's at the State level so your industrial sites can –

Olsson: It will save us this discussion in 2 years.

Yes. That's my suggestion, sorry.

DiRubbo: Your suggestion would be to leave as is, Shawn?

Yes.

I'll put it up for a vote, to leave it as is --

Olsson: So is that a motion?

That's a motion.

Olsson: Do we have a second?

I'll second.

Olsson: Any other discussion? All in favor of said document as is. All opposed. Carried. All right, you're on a roll.

All right.

Surprenant: The capnography form. One of the things that came up with the advisory is that SEMAC and the State would like information on every time capnography is used for patients. So as a region we have to provide that. So one of the things we came up with is the six regions instead of 18 different forms being out there, we decided that at least 6 of the regions would have a similar form that fulfills the State's requirements and one of the pieces on there was the fact that there is a provider section and there is a physician section, very similar to our intubation forms before. So the State would like us to -- not a study, but a QI project that identifies every time that intubation is done and then capnography and as you see location of intubation, provider level, number of attempts, confirmation and there will be a signature by the physician as well as any notes and this would be turned into the region and we in turn would have to submit those to the State for compliance. The Midstate and North Country REMACs had met prior to this meeting and they have approved this. We did bring this up to Regional QI and _____ comment that in the provider section it also had a

section that says transferred care from and list the agency because there might be an ALS FR on the scene that has performed intubation and they are just continuing care.

Why do we even have to do a physician confirmation _____.

I was just thinking that.

Surprenant: We're finding out that, I agree, we're finding out across the State that not every hospital has wave form capnography ____

Right, but in our region EMS folks have it on the ambulances, and they're going to need to document that so to me that would be a confirmation there that would not necessarily require the physician to sign off on, another confirmation, if they ____

Olsson: I think that the intent is to instill into the physician, instill in their ED director that we need to do this. It will give us a little more information how many times capnography is not being done in the ED and then we either regionally or State-wide we go to the proverbial powers to be and say, look, we're doing this in the field, this is the standard of whatever and here's the numbers.

Wallis: Why are you enforcing a standard of care on EMS providers and not the hospitals?

Olsson: So that came up at the SEMAC, and we can't dictate what the hospitals do. But we felt that at the SEMAC if we're taking someone's airway away from them we better make darn sure that we've got that tube where it needs to be.

Wallis: And continuous wave form capnography verifies that.

Olsson: Absolutely. So that's the method we've gotten.

Better than anything else that we have access to.

Flynn: I think that the physician confirmation section as it is actually gives -- may give you some really good information because the fact of the matter is you may have somebody who brings a

patient in and unfortunately it says look at this wonderful wave form and it has nothing to do with what a good intubation should look like, there are problems there, and you know it is important for the physician to document if it was misinterpreted or something like that. You also have the issue of the _____ person who is not making a _____ CO2, whether it is going to be appropriate for wave form _____ at least we'll get some information.

I think that's good for many of us here, but different emergency departments have different levels of physicians that are staffing them. Quite frankly I think there are – I think that there are paramedics out there that probably assess better than some of the physicians _____

But just as we've done in the past, intubation, where the receiving physician signs and proper tube placement by "x" number of methods, that's _____, and it does give -- _____, you know, we're using wave form capnography and we've transported "x" number of patients and yet none of you with the emergency departments can continue that. It's a nice thing to be able to take to the hospitals and say, you're really behind the curve.

Olsson: All right, our intent would be to start this at or around the time of the new protocols as well.

Calley: Dr. Olsson?

Olsson: Yes.

Calley: One thing I'm going to offer up is that if you're going to kick this off with the new protocols, then those of us who are doing the trainings need to have this in our hot little hand with the policy statement tomorrow so because we already have our training planned.

Olsson: Right.

Calley: And I need to get this to the people that are training in order to make sure that they've got time to review it and present it.

Olsson: Okay, however, we do need approval so any further comments, questions, concerns,

disagreements, _____, all in favor of the form as it is. Opposed? Carried.

Surprenant: We are just going to do a quick EMS chart update. We've got Brock Fire that will be coming onto EMS charts. We also have Minoa and Dewitt that will be going live on August 1st and Fayetteville went live on May 7th, and we also have Troy from Rural Metro, we need to have approval to be able use the Zoll product within this region. We've already approved that, both in Council and REMAC, for EMS charts, and you need to do the same for Zoll. Troy, do you have anything to add to your project?

Hogue: Not really, we've had the discussion here before _____ Rural Metro is going to be using the Zoll product and it's my understanding that there may be a hand full of other agencies that may be switching to that as well. _____. You know, we'll get you whatever _____ so it's a very, very robust product. It's NEMESIS compliant _____, and we can do a data export _____ REMAC _____. It operates very well with our CAD _____. There is talk within a number of agencies about _____ actually uses the Zoll billing system _____. You'll see more than just Rural Metro.

Surprenant: One of the things that we have is the Memorandum of Understanding that goes between the _____ that is coming on. I have met previously with Troy to discuss how that's going to happen so all we have to do is _____ EMS charts and the MOU with the region, we will have to do the same thing with Zoll so we will just have to update the current MOU that's in place to incorporate Zoll. So Troy and I will meet again, we'll update the MOU so it reflects the new product as well as the EMS chart product. Then also we've got our Council meeting next week so we will also bring it up at Council for vote and approval. The other thing we have is Glow Golf is going to be coming up so we will be distributing information on that in the email system, but we're looking at September 18th for our Glow Golf where we play either miniature golf or traditional golf. The other thing that we're going to be raffling off there is a handmade quilt that Tammy did. It's queen size and it sits behind me, and it actually has Air Medical, EMS, fire and police represented, and there is black

band around that and what it does it honors the providers of the past, present and future and fallen providers of our region as well as the State so that's why it's – it includes all of the public services. So we do have raffle tickets on sale and it is handmade and it's queen size.

Olsson: Since I neglected to ask, any other old business?

Hogue: There is – a couple of months ago the Regional Council asked the REMAC if they would look at the structure of physician members of REMAC and come up with recommendations to be more reflective of EMS, the EMS community –

(Ended)