EMSAC General Session Minutes
February 23, 2012

COMMITTEE MEMBER ATTENDEES:
Jim Allen, Third Service Non-Transport Member
Kevin Amorebieta, Advanced EMT Member
Kevin Bollar, EMT-Paramedic Member
Joe Cladouhos, Idaho Hospital Association Member
Les Eaves, County EMS Administrator Member
Greg Gilbert, EMT Basic Member
Denise Gill, Idaho Association of Counties Member
Robert Hansen, Fire Department Based Non-Transport Member
Gretchen Hayes, Volunteer Third Service Member
David Kim, Idaho Chapter of ACEP Member
Scott Long, Idaho Fire Chiefs Association Member
Doug Mazza, Private Agency Member
Mike McGrane, Air Medical Member
Bill Morgan, Committee on Trauma of the Idaho Chapter of ACS Member
Travis Myklebust, EMS Instructor Member
Kathy Stevens, Idaho Chapter of the American Academy of Pediatricians Member
Murry Sturkie, DO, Idaho Medical Association Member
Mark Urban, Pediatric Emergency Medicine Member
Mark Zandhuisen, Career Third Service Member

COMMITTEE MEMBERS ABSENT:
Catherine Mabbutt, Board of Nursing Member
Pat Tucker, Consumer Member

VACANT MEMBER SEATS

EMS STAFF ATTENDEES:
Michele Carreras
Kay Chicoine
John Cramer
Wayne Denny
Cody Dribnak
Tom Fogg
Barbara Freeman
Tara Knight
Erin Shumard
Chris Stoker
Season Woods

Other Attendees:
Bill Arsenault, Wildland Fire
Marc Essary, Air St Luke's Boise
Scott Hayes, Priest Lake Ambulance
John Lewis, Madison County Ambulance
Melanie Skiftun, Donnelly EMS
Mike Weimer, LifeFlight Network, LLC

General

EMSAC welcomes three new members: Greg Gilbert, Gretchen Hayes, and Kevin Bollar. Cathy Mabbutt has been appointed for another term for the Board of Nursing.

Minutes from the October meeting were approved.

Next meetings will be: June 28, 29 2012; Oct 17-18 2012; Feb 7, 2013

Future of EMSAC – Wayne Denny

Wayne Denny updated EMSAC about legislative activity. In the Bureau rules, the Board of Medicine EMSAC seat that has been vacant since the formation of the Physician Commission was changed to a seat to represent the Idaho Transportation Department.

The Personnel and Investigation rules became permanent.

The Physician Commission rules went through the Senate but were rejected by the House. There was confusion and discussion about continuing education issues that were in the personnel rules which are unrelated to the scope of practice issues. However, the rules should still become effective because it is not a fee rule and had already passed the Senate.

Another piece of legislation is SB 1294 that would amend the law that deals with advanced directives. The EMS Bureau found some of the language in the bill confusing and worked with the author to assure that EMS personnel are not required to honor a multitude of other DNR orders.

Wayne asked for feedback from committee members about how EMSAC should function in the future. What can we do better?

In the past, the licensure subcommittee made determinations of whether a specific agency received a license. The Bureau's deputy attorney general opinion is that license must be issued based on objective criteria and not subjective evaluation. The subcommittee now recommends policy changes.

We need to look at the makeup and responsibilities of subcommittee members.

- Do we need more subcommittees?
- There are special population usage groups such as wilderness fire. How do you foresee these groups?
- Do we form an ad hoc subcommittee as issues arise?
- Are we talking about the right stuff?
- Most members sit in on most of the subcommittee discussions. Is it desirable to take the time to report the same information in the general session?
- Are committee members in touch with their constituents?

Suggestions included:

- Activities focused on prevention
- Form a subcommittee to discuss issues related to data collection, track trends, decision making, ways of obtaining data, data elements, aggregated information from trauma registry, etc.
- Form a trauma subcommittee. (There is a Quality Planning Commission that has been appointed by the governor that is exploring implementing a trauma system in Idaho. This could be a forum for discussion of related issues).
- Community para medicine

- Feedback to the Physician Commission
- Regular report from the Physician Commission
- BLM needs representation
- Form a subcommittee for personnel licensing issues
- Bureau should request agenda items from subcommittee chairs

Subcommittee size and meeting frequency was discussed. There is no requirement that every subcommittee meets every meeting cycle. They should convene depending on germane issues. There might be some value to adding ad hoc members, but it can slow down the discussion and decision making process. The EMS rules don't define the subcommittees. They need to be dynamic. EMSAC is satisfied with current subcommittee configuration but would welcome new subcommittees as discussed earlier.

The concept of using regional meetings to garner feedback from constituents was discussed. Dean Neufeld further explained a possible regional structure of advisory groups with a cross section representation (hospital, agency, etc) that would meet under the direction of the Bureau and discuss local issues. These groups could focus more on pre-hospital delivery rather than the support as represented in current EMSAC membership. The EMSAC member could participate by attending, reviewing minutes, and bringing feedback to the general session.

There were four members who had current awareness of potential regional meetings in their area.

How many agencies know that they have a representative on EMSAC? How do we make EMSAC member contact information accessible? Do EMSAC members want their information published? Blogs could be used to keep in touch with constituency.

Although Mark Zandhuisen had limited success when he reached out to providers in his area when he was initially appointed to EMSAC, there is a need for providers and stakeholders to be aware of who represents them at EMSAC.

The Bureau will publish a list of EMSAC members and contact information on their website. If any of the members have concerns about having their information published, contact the Bureau.

Wayne expressed appreciation to the EMSAC for their valuable feedback. Whenever a question about the Bureau's awareness of system needs, he can confirm that there has been collaboration with the representatives on EMSAC.

DNR/POST – Chris Stoker

Chris Stoker presented pending legislation about Physician Orders for Scope of Treatment (POST) and asked for EMSAC approval for current guidelines.

It was perceived that the pending legislation removes standardization of the DNR forms which causes confusion with pre-hospital care scenarios.

Wayne Denny clarified that the intent is for standardization. The language, however, is confusing and somewhat circular. The Department of Health and Welfare will have authority to develop the form. When rules are written, it will be clear that EMS providers only have to honor a POST.

A question arose about whether a provider can honor the Secretary of State registration card as a DNR. Is the card any different than the jewelry? A card only means that you have an advanced directive of some sort registered with Secretary of State, but is meaningless in the pre-hospital setting.

If you don't have POST and a family member is telling the provider not to resuscitate, call medical control. Idaho law doesn't define "consent". If this bill passes, we're going to have to modify our rules

to focus attention to the guideline and not the form.

GENERAL SESSION MOTIONS

A motion to recommend approving the POST guidelines as they currently stand was seconded and carried.

Investigation

The number of investigations has been increasing over the last 5 years. Some of that may be due to more awareness because of the National Practitioner's Data Bank. The number of cases have been:

- FY 2008 22
- FY 2009 38
- FY 2010 35
- FY 2011 52
- FY 2012 27 (ytd)
- Total 174

There are currently 32 open cases.

Tawni Taylor described the different outcomes and license actions for personnel and agencies. There are fines for the following:

- Operating an Unlicensed EMS Agency
- Unlicensed Personnel Providing Patient Care
- Failure to Respond to 911 Call
- Unauthorized Response by an EMS Agency
- Failure to Allow Inspection
- Failure to Correct Unacceptable Conditions
- Failure to Report Patient Care Data

Tawni informed EMSAC about the outcomes from the August peer review.

Transition Update – Chris Stoker

Five providers have transitioned and received their updated license. Chris Stoker showed a sample of the new license.

The Bureau is communicating the transition process by several methods: letter, email, postcards, pamphlets, FAQs, webinar series, formal presentations, site visits, meeting minutes and conferences.

There have been changes that extend the existing timeline:

- Initial Exam 10/1/10-3/31/11
- EMR/EMT transition must be completed by 3/31/2017
- AEMT/Paramedic transition must be completed by 3/31/2016
- EMSPC
- New scope effective July 1, 2012

The new scope for AEMT/Paramedic is effective July 1, 2012. But, transitioned AEMTs/Paramedics will not be issued new licenses until January 1, 2013. There will be a gap between July 1, 2012 and January 1, 2013 when these providers will have to practice at the old scope, even though the new scope is technically in effect.

Chris listed resources that are available to assist those who will transition. Our website includes updated

FAQs, recorded webinars, extrication awareness, HazMat, ICS and NIMS. There are forms for transition course individual CE tracking, updated practical exam skill sheets, and instruction guidelines.

New scope of practice initial and transition courses must identify a course physician to all levels. At the BLS level a designee can be named to verify competency. Medical directors will continue to credential personnel & validate skills. They also have discretion to limit the scope of practice.

Some changes from the Physician Commission meetings are:

November 2011 (takes effect July 1,2012):
- Remove Intubation from AEMT SoP
- Epi Auto Injector added to EMT-11 floor
- Tourniquet added to EMR-11 floor

February 2012 (takes effect July 1, 2013):
- Epi IM authorized as a 2,4 OM for EMR, EMT, AEMT-85
- AEMT-85 authorized to take EMT-2011 transition course for additional skills.(Effective immediately)

Chris described the additional floor skills for an AEMT-85 who has completed an EMT-11 Transition course:

New floor skills from EMT-2011 scope:
- ATV non-intubated
- Atropine Sulfate & Pralidoxime Chloride AI (MARK-I, DuoDote)

New floor skills previously AEMT-85 OMs:
- Pulse Oximetry
- Asprin
- Epi Auto Injector

Discussion

Confusion over the AEMT85 is an unintended consequence: The Physician Commission will not force AEMT85s to transition and are standing by the decision to maintain AEMT85 level. This group wanted to stay where they were. Transfer of care became an issue that has now been addressed. The agency/provider may prefer to transition.

Education requirements haven't changed, but there are scope issues. Wayne clarified that continuing education changes are due to rule changes and are not caused by transition. Refresher courses were eliminated because of feedback during negotiated rule making. The hours of CE haven't changed. It is easier to accomplish because the provider doesn't have to dedicate time to the refresher.

Denise Gill asked about an alternative for the advanced EMT because there are only a few skill differences with 4 medications and 3 techniques. Could there be a competency exam for just those skills. Wayne replied that there was a depth and breadth of knowledge beyond those skills that needed to be addressed with education and exams. It's more than just the numbered skills.

Murry Sturkie affirmed that the initial goal was not focused on making the process easier. The AEMT level was frozen as a promise to that level.

Air Medical Subcommittee – Mike McGrane

Weather Turndowns and

Helicopter Shopping

The subcommittee discussed the hazards of not communicating previous weather turn downs when requesting an air medical service and ways to reduce the frequency of this practice of helicopter shopping.

There isn't a central clearinghouse for this activity. When StateComm is managing a call, all relevant information is relayed, but they don't dispatch all requests for air medical.

It would be valuable if more agencies were aware of and entered data into www.weatherturndown.com. How do we get out the word?

Related to weather turndowns, is the practice of helicopter shopping. Communication from all involved is necessary to maximize the efficient and safe use of air medical support.

Designated Landing Zones

More air medical agencies are beginning to prefer designated landing sites. The subcommittee suggested maintaining a catalog of Idaho landing sites with locations and photos at StateComm. EMS agencies need to know where the patient can be transported by air medical.

The goal is to catalog Idaho landing sites through Northwest Air Ambulance Responders (NWAAR).

Bill Morgan informed the subcommittee that the State Board of Aeronautics has a publication of all airfields. He suggested that the Air Medical subcommittee contact them about publishing landing zones.

Idaho Resource Tracking

Michele Carreras demonstrated the Idaho Resource Tracking system that was initiated about 2 ½ years ago for hospital bed tracking. StateComm is a user of the program and monitors it 24/7. StateComm can create an event and select hospitals that need to be notified of an event. There is capability in the system to add hazmat and air medical availability. Weather turndowns could also be documented here. This is a great tool, but it is underused. If used appropriately, StateComm could have real time information about air medical agencies. All would have to participate in order for this to be a reliable resource. Michele stated that it would also be another step in dispatch protocols. SkyConnect was also suggested as a real time resource.

Jim Allen reminded the subcommittee that some of these electronic internet based solutions might be difficult or impossible in some rural areas.

Subcommittee Motions
(Approved by General Session)

A motion to recommend the EMS Bureau communicate the availability of weatherturndown.com for all EMS agencies to create awareness of air medical turndowns was seconded and carried.

A motion to recommend the EMS Bureau review the LZ training course and emphasize the weather turndown and helicopter shopping portion was seconded and carried.

A motion to recommend that air medical agencies communicate directly with StateComm in addition to the other programs whenever there is a turndown was seconded and carried.

A motion to recommend that the air medical providers work with StateComm and the State Board of Aeronautics to develop a state catalog of designated landing sites was seconded and carried.

Grants Subcommittee – Travis Myklebust

January Meeting Recap

Tom Fogg recapped the actions and motions from the Go-to-Meeting that was held January 9, 2012.

Motions at that meeting were to

- move pulse oximeters off the ineligible list (but not to fund if it is part of a blood pressure monitor)
- place video laryngoscopes, mechanical CPR devices and cot loading systems on the ineligible list
- price cap for vehicles will remain unchanged

Assignments were to investigate costs of AEDs for the last grant cycle and current market prices and reduce the price cap if warranted. Price ranges for auto transport ventilators and pulse oximeters also need to be checked. Tom checked rule and statute for information about the exclusion of disposable items.

The AED prices from the last grant cycle ranged from the less expensive of $1,245 (Defibtech) to $2,609 (Lifepak). There were 27 requests for AED's for an average cost of $1,580.

The subcommittee discussed not changing price caps for pediatric items on the minimum equipment list.

The subcommittee expressed interest in locating funding for education. This might be a possibility as the fleets are updated. But it would require a rule change. Currently legislators are concerned about education costs.

There was a suggestion to look at the way grants would be awarded to EMS systems if the rules are opened for revision.

Epi-Pen Discussion

Dr. Sturkie reported that the topic of epinephrine injectors vs. IM injections was taken to the physician commission for a decision on direction/options. The cost of injectors has gone way up - nearly double the current price cap.

Intra Muscular epi injection will be an optional module for EMT and AEMT beginning July 1, 2013.

Tom reported that disposable items are not mentioned in the Account III grant rule and is only mentioned in the Standards Manual. It is not possible to have a security interest on disposable items. Epi-pens have been removed from the FY 2013 grant application as a separate item but can be requested as a priority equipment item. When requesting eip, both pediatric and adult injectors can be requested as one item priority request. Maximum of two epi injectors plus one spare can also be requested as one priority request.

Price Caps/Ineligible Items

There is no price cap currently on auto BP monitors price caps. Subcommittee members reported that they are inaccurate and expensive to use.

Although there is evidence that the power gurney reduces back injuries, the cap was not changed.

FY2013 Application

The subcommittee reported that the pilot for the FY2013 grant application and guide went well and the application format received compliments. The goal was to clarify the questions and eliminate last year's problems. One new process is that the agencies will request a vehicle fleet report from the Bureau to complete the form. The agency can make revisions to the report and the information is used for the grant

calculations.

A webinar will be held March 13, 2012 to give tips in completing the application.

There was discussion about defining in a consistent way the time and distance of similar equipment. This is a requirement for grant calculation and applies to more than just extrication equipment. The decision was to use the same definition that the Office of Highway Safety uses in their grant application. Murry Sturkie suggested using a drop down with percentages or ranges.

Narrative Scoring

There will be a change in the PERCS records submission requirements this year. Last year an application was disqualified if the agency did not have adequate PERCS submission. John Cramer suggested that the subcommittee look at the intent to submit. There are times when the validation process can be lengthy. He said that there may be some correlation to the desire to apply for grants and submitting patient records. Check boxes will be added to the application on the equipment narrative pages to ascertain compliance with PERCS, communications plans when requesting radios and training for extrication equipment. The absence of these items will result in a lower narrative score.

Subcommittee Motions
(Approved by the General Session)

A motion to recommend that in order to award grant funds for a pulse oximeter device, the device must be pediatric compliant was seconded and carried.

A motion to recommend a price cap of $2,800 for automatic transport ventilators was seconded and carried.

A motion to recommend placing the auto BP monitors on the ineligible list was seconded and carried.

A motion to recommend scoring the narrative with a “0” if the agency is not PERCS compliant was seconded and carried.

A motion to recommend scoring the narrative with a “ 0” if the agency does not have a communications plan or the request is not consistent with the plan when requesting communications equipment was seconded and carried.

A motion to recommendation to score the narrative with a “ 0“ if the agency doesn’t provide Operations Level Training and specific training to the equipment requested was seconded and carried.

Licensure Subcommittee – Dean Neufeld

Agency Licensure Activity

Dean Neufeld reviewed the new agency licenses that have been processed.

1. CenturyLink Arena – BLS Non Transport. A standby for venues that come to Boise. It consists of Boise fire fighters and will have their own medical direction from the occupational medicine group for the complex.
2. Shoshone County FD # 2 upgrade BLS-ILS Non Transport. This agency is using Firehouse and has yet to submit a valid data export. They have decided to use PERCS.
3. Atlanta Quick Response Unit BLS Non Transport. There was a deadline for licensing providers by the end of 2011. The evaluation of the medical plan is done by the Physician Commission.

Pending licenses are:

1. Meadows Valley Ambulance- Upgrade BLS- ILS
2. Teton County Fire District- Upgrade BLS- ALS NT
3. Elmore Ambulance Service- Requesting NT license for Oasis
4. Shoshone County EMS Corporation ILS Ambulance

Dean discussed the need for rules to address licensing EMS systems, outline notification process, cost analysis, etc. Currently separate licenses are issued for differing service types, clinical level, or geographical response area (self declared).

Currently have 202 separate agencies and 213 separate licenses. Divided by region:

- Region 1 – 41, Region 2 – 27, Region 3 – 23, Region 4 – 26, Region 5 – 42, Region 6 – 21, Region 7 – 22, Total - 202

Provider Licensure Activity

Dean compared the number of provider licenses in November 2011
(363 EMR, 2619 EMT, 930 AEMT and 637 Paramedic, for a total of 4,549 provider licenses)

and on February 14, 2012
(376 EMR, 2,738 EMT, 969 AEM, 674 Paramedics, for a total of 4,757 provider licenses)

Certificate of Eligibility

Dean presented the new Certificate of Eligibility that is available effective 7/1/2011 to candidates who meet all requirements for licensure except affiliation. It is intended for candidates who may be looking for a job and initial licensure or wanting to remain eligible and available for licensure when they do not have affiliation to renew a license. It can also be useful for those who want to remain eligible for a higher level of license when they do not currently have affiliation at that license level. This is advantageous to the agencies because they only need to credential the applicant. The agency would know whether the applicant is hirable. The individual would have to maintain CEUs and testing for renewal.

The Bureau has issued 5 certificates of eligibility.

Inspection/Equipment Report

Dean presented the inspection/equipment report. June 2012 will mark a full year of inspections based on the new cycle model. New equipment standards took effect on July 1, 2011. This first year, the Bureau focused on identifying deficiencies and giving information. Most agencies attempted to comply with new standards on first attempt. Some of the common equipment deficiencies based on the new standard are pediatric sized airway management (NPA, OPA, Masks, Suction Catheters), pediatric immobilization, and miscellaneous items such as ring cutters, trauma bands, and infection control.

If an agency did not want to comply with the new list, they were requested to ask their medical director to submit an exception with justification for review. Rules allow the EMS Bureau to grant exceptions upon inspection when circumstances and available alternatives assure that appropriate patient care will be provided for all foreseeable incidents. The Bureau also confers with the Physician Commission when needed.

Current exception requests are:

1. An ALS ambulance requests exception to burn sheet requirement because St Alphonsus Hospital and Salt Lake City Burn Center do not recommend their use. The medical director research and submission recommends dry sterile dressings.

2. A BLS nontransport that deals with industrial wildland fires and treats fellow injured firefighters requested exception for pediatric equipment, OB equipment , ERG, fire extinguisher, gowns, shoe covers, N-95 masks, ring cutters, safety vests, and trauma bands.

An agency needing more time is not an exception. It is a deficiency that can be corrected.

The subcommittee suggested maintaining and publishing a list of approved exceptions for a clinical or operational perspective. If the receiving facility doesn't recommend a piece of equipment, an alternative should be identified.

Trauma bands are required equipment, but there is not a requirement to use the bands.

National Association of EMS Officials (NASEMSO) Equipment List Draft

All State EMS offices have been asked to provide comments to the equipment list to NASEMSO. The comments will be compiled for consideration by the working group.

This list would not be a comparable list with the Idaho list as to the number pieces of equipment.

The suggestions from the subcommittee included:

- Implement some mechanism to accommodate a change in real time when there is medical evidence for a change.
- Consider training time when introducing new equipment
- Avoid making hasty changes.

The subcommittee asked how much weight these national guidelines would have. This would be a references to legitimate studies, feedback or data. Some initiatives are based on clinical guidelines. There's more than one way to get to the end point. We need to be pro-active so that we have quality care with the right equipment.

Subcommittee Motions
(Approved by the General Session)

A motion to recommend the Bureau make an exception for this unit (ALS agency requesting exception for burn sheets) based on the medical director's direction was seconded and carried.

A motion to recommend leaving the ring cutters on the list was seconded and carried.

EMSC Subcommittee – Bill Morgan

School Nurse Representative

Erin Shumard introduced Barbara Thomas, who is a school nurse, and is visiting EMSAC as a potential representative for school nurses. She has been a school nurse at Borah High School and has an interest in EMS as well as 9 years of family practice experience and 25 years of school nursing experience.

Other Funding Opportunities

Erin Shumard informed the subcommittee of two grants that had come to the attention of EMSC.

The State Partnership Regionalization of Care Demonstration Grant (SPROC). The amount is $200,000 over four years and targets underserved and/or isolated populations such as tribal and rural populations. The goal of the grant is to create a pediatric regionalization model program that assures "seamless

access" to pediatric specialty care through transfers or shared medical resources. Eligible applicants are state agencies with established partnerships with the target populations.

Erin considered the EMS Bureau ineligible for this grant due to the emphasis on already established partnerships between the grantee and the target population, lack of authority over hospitals (especially when transfers are inter-state) and the lack of infrastructure to identify pediatric specialty care centers.

Erin further explained that the grant guidance specified and placed heavy emphasis on using already established relationships and partnering with a cultural broker, someone who is already involved with and has a deep understanding of the target populations. At this time, there are no such partnerships between the EMSC Program and representatives from these populations. The EMS Bureau has no authority over hospitals, and has had limited success with transfer agreements in Idaho. Trying to implement a regionalized system for pediatrics with little buy-in from hospitals would be very challenging, especially when it comes to inter-state transfers.

There is also a lack of designation to help identify and route patients to pediatric specialty care centers.

However, the EMSC program can

- focus on underserved populations in rural and tribal communities (Performance Measure 76 & 77)
- consider pediatric patients as trauma/regionalization system forms in Idaho (Performance Measure 74 & 75)
- reach out to target populations to identify gaps that may be addressed in other ways

Murry Sturkie pointed out the partnerships that are already represented by EMSAC members. Erin replied that the cultural broker needs to be in the target population and that EMSC will establish partnerships to be prepared for future opportunities.

The second grant opportunity is from the State Implementation Grants for Systems of Services for Children and Youth with Special Health Care Needs (**CYSHCN**). The amount is up to $300,000 per year for 3 years and is targeted to children and youth with special health care needs and their families. The goal is to improve access to a quality, comprehensive, coordinated community-based system of services for CYSHCN and their families that is family-centered and culturally competent.

Eligible applicants are State Title V Programs for CSHCN or groups that work directly with the State Title V Program.

This goal doesn't fall under the EMS Bureau scope and this grant opportunity has been referred to the Developmental Disabilities Program in the Department of Health and Welfare.

The EMSC program will continue to educate pre-hospital providers about Children with Special Health Care Needs, promote family-centered care in the EMS community, and consider CSHCN as the trend toward regionalization of care continues and a system forms in Idaho.

Discussion

Kathy Stevens asked whether there is a registry for special needs children in Idaho. John Cramer replied that there currently isn't statutory authority and getting funding for a centralized registry can be challenging. Erin said she would investigate what other states are doing. Nanette Hiller suggested that the Idaho Health Data Exchange (IHDE) could be a home for this information. Bill Morgan commented that information about special needs adults would also be valuable. He mentioned that the IHDE doesn't have authority to require input.

A web based system that interacts with the CAD system would enhance dispatching to these patients.

Pediatric Training Updates

Since the last EMSAC meeting, there have been several pediatric training opportunities around the state. Regional conferences were held in Boise and Sun Valley. The Grangeville EMT Association will be hosting Spring Fling on March 3, 2012.

Providers began asking last month about the Sacred Heart TeleHealth Series. These courses will be available monthly during the academic year. So far, the topics we've seen covered include: Shock & Tourniquets, Hypothermia & Cold Injury, and Geriatric Trauma.

Beginning in November, CAH trainings were held at Cassia and Minidoka hospitals as well as at St Luke's Wood River. More hospitals are signing up for training such as Syringa and Bonner General. These opportunities for hospital and EMS staff to practice together has great value.

Erin is working with Veronica Jones of Kootenai County EMS to set up an EPC Course. There is a lot of interest in the course.

Website Updates

Erin announced that she is improving the EMSC information on the Idaho EMS website (www.idahoems.org). Previously the information was about guidelines, training opportunities, and EZ-IO Needle Requests. Erin has added performance measures, injury prevention information, and current EMSC activities. Erin asked for feedback about other topics to add.

Use of Remaining Awards

Erin reported on the final purchases for the EMSC grant year ending February 28, 2012

New Grant Cycle

The EMSC grant for 2012-2013 was a non-competing continuance. The Bureau doesn't expect any changes in funding. EMSC will continue the work from the 2011-2012 grant year such as focusing on education by supporting regional EMS conferences, funding and coordinating EPC courses throughout the state, and due to feedback received from the CAH trainings, funding four more CAH trainings. A big focus will be on providing equipment based on meeting minimum pediatric equipment requirements.

Meeting Planning

One of the requirements for the grant is to hold four meetings in the year. The EMSAC meetings only provide an opportunity for 3 meetings. The subcommittee suggested a Go-To Meeting in April.

National EMSC News

Erin presented information about the Therapeutic Hypothermia After Pediatric Cardiac Arrest (THAPCA) Trials. This is the first large scale multi-center study to help determine the best treatment for kids who are successfully resuscitated after a cardiac arrest. There are 37 clinical centers participating. Those in our area are Primary Children's and Seattle Children's. Kathy Stevens stated that St. Luke's is interested.

More information at www.thapca.org.

AED Legislation

Erin presented information submitted by Pat Tucker who has been working with Senator Dean Mortimer of Idaho Falls to introduce legislation about placing AEDs in Idaho schools. This is largely a nonbinding

resolution that has several supporters such as the Boise Chapter of the AHA. Some points in the resolution are: to have schools acknowledge the importance of having an AED on campus; recommend CPR/AED education for high school graduation; encourage having a traveling unit at sports events; to provide trained staff; to suggest CPR/AED training for a teaching certification and to incorporate CPR/AED use in school emergency plans.

Education Subcommittee – Jim Allen

Review of Education Equipment

The subcommittee reviewed the equipment lists required when teaching courses at all clinical levels (EMR, EMT, AEMT, and Paramedic). The goal was to determine reasonable requirements.

At times there was confusion about the agency licensure minimum equipment list as opposed to the education list. Fancy, expensive equipment is not necessarily the best option as long as the concept can be taught. Videos can be used for training in lieu of some equipment. Also, a medical director may restrict certain procedures, but the student needs to be trained to all.

Subcommittee Motions
(Approved by General Session)

A motion to recommend removing Mechanical CPR device, ATV, Demand Valve equipment for training purposes at all levels was seconded and carried. John Lewis opposed.