

REGION IV NEWS



Volume 2; Issue 1

Spring 2008

From the Desk of the Executive Director - John Guidara, MS, MBA

This year, I think we're all looking for the end of snow and the flu and the start of brighter days. Fortunately, they're on the way. Although the winter was tough, our work in EMS Region IV moved along at a steady pace and kept us in touch with our constituents. I want to take a minute or so to share some of our progress with you.

Last May, we submitted a proposal to the Lahey Clinic Community Benefit Fund for an Emergency Preparedness grant and were very pleased to receive a one hundred thousand dollar award to be used for training, education, computer upgrades and the purchase of a Regional SUV equipped with appropriate radio and communications equipment. With this funding, we have already bought the vehicle and offered a very successful all-day Educational Forum last December, which more than seventy EMS personnel attended. Our Annual Awards Banquet was held in October in Newton, and we were proud to present awards in nineteen different categories and to celebrate this event with close to two hundred fifty people in attendance. The Region is participating in the Partnership for Emergency Preparedness (PEER) grant with the Boston University School of Public Health. This is an exciting eight-month project addressing the most consistent and critical communication problems encountered during emergency response. The project will improve communication strategies and protocols among five health and medical disciplines in Boston and 61 surrounding communities. The five disciplines include: community health centers, EMS agencies, hospitals, long-term care facilities and public health agencies. Needless to say, we have also been busy collaborating with the Office of Emergency Medical Services (OEMS) on various issues such as service zone planning, P/B waiver requests and discussions, protocol development and a draft point-of-entry plan for hospital destination, other than closest, based on a patient's specific condition and need. In terms of service zone plans, our Region has received forty-five service zone planning applications. There have been six plans approved in Region IV: Ashland, Boston, Dover, Lincoln, Maynard and Wayland. Several others are in various stages of discussion between the Region and the communities.

You'll find that this third issue of Region IV News has a lot of interesting information, and of course, some humor, courtesy of Steve Berry. There's a short note about Committee participation. We're always looking for fresh new ideas and Regional input. Belonging to one of our Committees gives you this opportunity to be heard and to influence change. Consider getting involved.

In this issue, our Medical Director, Dr. Charles Pozner, discusses airway management and ventilation strategies. He believes that the EMS community "must do a better job in providing these life-saving skills." In this article you'll learn his views and conclusions.

The Express Yourself column sheds a new light on whether the differences in EMS are really so insurmountable. Do we lose perspective and get caught up in turf issues and consequently miss the bigger picture?

You'll also be able to read about telemedicine which is starting to take hold in prehospital care, but why is it taking so long? Last but not least, take a few minutes to read a timely article on the National EMS Scope of Practice model.

Until our next newsletter, be well and make the best of each day!



The National EMS Scope of Practice Model is a continuation of the commitment of the National Highway Traffic Safety Administration and the Health Resources and Services Administration to the implementation of the EMS Agenda for the Future. It is part of an integrated, interdependent system, first proposed in the EMS Education Agenda for the Future: A Systems Approach which endeavors to maximize efficiency, consistency of instructional quality, and student competence. Many organizations were included on the National Review Team, including NASEMSO. Also, many NASEMSO members, NASEMSO Executive Director Elizabeth Armstrong, and other NASEMSO staff members played critical roles in the areas of task group representation, administration of the project, and in a technical advisory capacity.

The National EMS Scope of Practice Model supports a system of EMS personnel licensure that is common in other allied health professions and is a guide for States in developing their Scope of Practice legislation, rules, and regulation. States following the National EMS Scope of Practice Model as closely as possible will increase the consistency of the nomenclature and competencies of EMS personnel nationwide, facilitate reciprocity, improve professional mobility and enhance the name recognition and public understanding of EMS.

The National EMS Scope of Practice Model defines and describes four levels of EMS licensure: Emergency Medical Responder (EMR), Emergency Medical Technician (EMT), Advanced EMT (AEMT), and Paramedic. Each level represents a unique role, set of skills, and knowledge base. National EMS Education Standards will be developed for each level. When used in conjunction with the National EMS Core Content, National EMS Certification, and National EMS Education Program Accreditation, the National EMS Scope of Practice Model and the National EMS Education Standards create a strong and interdependent system that will provide the foundation to assure the competency of out-of-hospital emergency medical personnel throughout the United States.

Article reprinted with permission from the NASEMSO Web site at www.nasemso.org.

Tips of the Season

- ✍ Communities in need of technical assistance in developing or completing their Service Zone Plans can contact the Region IV EMS office at (781) 505-4367. If you are looking for information regarding Service Zone Planning, you can go to www.mbemsc.org for more information and updates.
 - ✍ Dress for all weather. As we, EMS providers, approach springtime in New England we will no doubtedly experience the joys and the pains of the multiple temprature shifts and weather changes that always seem to happen everytime you turn around. As a reminder, remember to dress in layers so that you can adjust to our everchanging New England weather accordingly so that you can stay healthy and happy.
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A Patch From C-MED

All providers should remember that when hailing Metro Boston C-MED they need to **identify the city/town that they are communicating from, in addition to their unit ID.**

An example of a patch would be:

“Metro Boston C-MED, Metro Boston C-MED, this is Bedford A-2 in Burlington on Med-4”.

Medical channels are not assigned to providers based solely on call volume and priority; they are assigned based on geographic proximity to the radio towers. By providing your location when requesting a C-MED patch, you are allowing the operators to better serve you.

Should you have any questions regarding this policy, please contact the Region IV EMS office at (781) 505-4367.

From the Medical Director - Charles Pozner, MD

As some of you might already know, I have been asked to chair an OEMS Medical Services Committee subcommittee on ventilation and airway management. I took on this role because it is my strong belief that we must all do a better job in providing these life-saving skills. Although there are strong feelings generated on the blogs and by the “water cooler” about the place for endotracheal intubation in the EMS armamentarium, we as a committee have decided to start our work by examining the basic airway and ventilation.

Through both my EMS teaching and my role as director of Code Team training at BWH, I do quite a bit of instruction on basic airway management. When I discuss bag-valve-mask (BVM) ventilation, I usually begin by asking the participants how many people it takes to adequately ventilate a patient with a BVM. Almost invariably the answer I receive is, “one person.” Now, if one has the hands of Goliath and provides BVM ventilation on a frequent basis and in a static environment, then one person may be able to perform this function adequately. However in the prehospital setting, this is a skill performed by providers “on-the-move,” with a wide range of experience, and with “human-sized” hands! The quality of one-person BVM is, at best, variable in this setting. In order to provide consistent, effective ventilation using a BVM, not only does one require adequate skills, but it is at least a two-person operation; with a third to providing cricoid pressure to minimize gastric insufflation.

Even in the operating room, during elective cases, mask ventilation was deemed insufficient, and in 1981 Dr. Archie Brain introduced the laryngeal mask airway (LMA). He asserted that an airway device must have two attributes, “It should overcome airway obstruction rapidly and easily; and it should be atraumatic, even when used by the unskilled.” Since the introduction of the LMA, a myriad of other supra- and extraglottic airway devices have been introduced, most of which can be blindly inserted with minimal training.

The EMS community has long been searching for the best airway management and ventilation device, evidenced by the introduction of endotracheal intubation and the esophageal obturator airway in the late 1970s. These strategies, no matter what one’s opinion is about them, have failed to address those patients managed by basic prehospital providers. This group of providers has been relegated to continuing to struggle with the BVM; long known to be inadequate in the controlled environment of the operating room.

It is past time that we reevaluate airway management and ventilation strategies for our basic providers. We must review the literature in order to select the most appropriate devices, provide adequate initial training, and re-educate these providers at an appropriate interval. If we must force our patients to wait for the arrival of our advanced providers when adequate ventilation is needed immediately we will lose many opportunities to provide this life-saving therapy that our patients need and that the community expects.

Want to Participate?

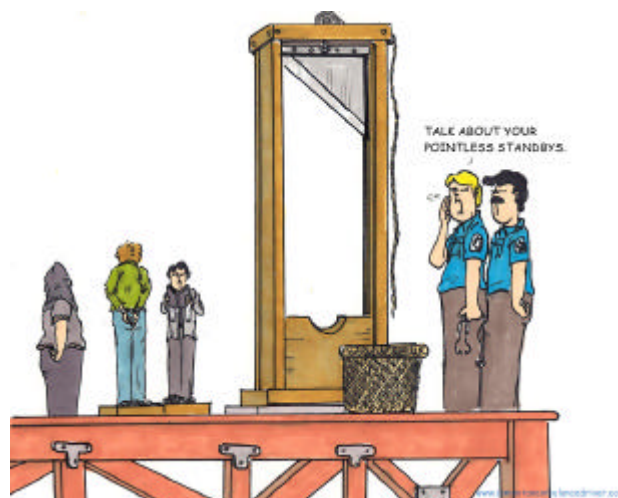
Interested in being on a Region IV committee? Want to contribute to EMS more? Let us know. The Metropolitan Boston EMS Council has four standing committees (Medical Control, Public Information & Education Resource, Pre-Hospital Systems Coordination, and Trauma Systems) that are always seeking individuals interested in providing their expertise to improving EMS in Region IV.

If you would like more information on the committees or the region, please visit www.mbemsc.org or contact us at (781) 505-4367. If you are interested in being on a committee, please send a letter to: Metropolitan Boston EMS Council, 25 B Street, Suite A, Burlington, MA 01803. Please include the committee you would like to participate on as well as some background information and the reason for wanting to participate. If you have any questions, please feel free to contact us.

And Now for a Brief Intermission....



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DOT Secretary Peters Appoints First NEMSAC Members

Department of Transportation Secretary Mary Peters has appointed 25 emergency medical services stakeholders to serve on the newly chartered National Emergency Medical Services Council (NEMSAC). The Council's mission is to provide NHTSA, part of DOT and the Federal Government's lead coordinating agency on EMS, with "inside the EMS community" recommendations and advice.

Leveraging Experience and Expertise

The NEMSAC appointees represent a wide range of emergency medical services disciplines and representatives, including volunteer and career EMS responders; EMS State directors; medical researchers and educators; highway safety professionals; dispatchers and air medical personnel; EMS physicians, surgeons, and nurses; data management specialists, homeland security experts, and others. (Region IV is proud that Board member, Chief Richard Serino of Boston EMS is an appointed member.)

Expanding Collaboration The NHTSA Office of EMS (OEMS) has always sought to facilitate a consensus-based process for developing effective Federal programs by collaborating with other Federal agencies and with EMS community representatives. In fact, understanding that the end-users of Federal emergency medical programs and products are EMS providers, OEMS has long held that EMS providers should be directly involved in the development of these Federal programs.

In 2006, NHTSA moved to formalize its collaborative approach to working with EMS providers, consumers, and other stakeholders. In keeping with the requirements of the Federal Advisory Committee Act (FACA) to utilize a group of citizens to provide ongoing recommendations to a Federal agency, NHTSA requested that an official committee of EMS stakeholders be chartered. In response, Transportation Secretary Peters determined that the establishment of an advisory committee was necessary, approved its formation, and NEMSAC was created.

An Overwhelming Response

On December 18, 2006, NHTSA put out a call for nominees to NEMSAC through the Federal Register. The response from the EMS community was overwhelming: more than 400 EMS representatives from across the country were nominated by their peers in less than two months' time. With so many qualified applicants, the selection process was a difficult one. In accordance with FACA requirements, NHTSA conducted a thorough review of all applications and sent a final nominee list to Secretary Peters for her consideration.

Additional Opportunities to Get Involved

NHTSA realizes that many more qualified individuals were nominated than could be appointed to the Council. However, interested parties can still make valuable contributions to NEMSAC in several ways. For example, an individual or organization may request to be placed on the NEMSAC mailing list, submit written comments to the Council, and attend NEMSAC meetings. Time will be set aside during each meeting for public comment. NHTSA encourages all those interested to take advantage of this opportunity to have your voice heard. Congratulations to all those appointees selected! The NHTSA OEMS team looks forward to working with NEMSAC, as well as the greater EMS community. Watch www.nhtsa.dot.gov for updates on NEMSAC activities.

Express Yourself.... (an individual article)

Our Differences and Challenges.... Are They Really That Insurmountable?

Derrick H.W. Congdon, M.S., NREMT-P

We in EMS always seem to be at odds with each other over something. We disagree over different things, usually many times over the course of years, and in the end were these issues or differences really as big as we made them. Couldn't we have sat down, put our jurisdictional and employer differences aside, and come to a consensus as EMS providers as to the best way to practice and administer EMS.

I think sometimes we lose perspective as to how small our differences and issues truly are. To try and give us some perspective maybe we should look at the EMS services in the Middle East and the harsh challenges that face these providers as they try to provide EMS care to the people around them.

The providers who work for the various services in Palestine, Israel, Lebanon and beyond are faced with differences and issues that truly make our disagreements in EMS pale in comparison.

Imagine working for the Palestinian Red Crescent Society (Palestinian ambulance service) and not being able to pass between different parts of your response area freely. PRCS ambulances are stopped and searched at all controlled borders with Israel. These stops (security checks) happen whether the ambulance is transporting a patient or not. Imagine being the EMT on this ambulance and being forced to have your ambulance searched for weapons or even explosives because of the very real fear that one of the ambulances could be a ruse for a terrorist attack. Not only is the ambulance searched but it is held in place at gun point.

This is daily life for these EMTs: searches enroute to calls, searches going back to a hospital and sometimes even searches at the hospitals. Many times ambulances are not permitted to pass through the security zones and must transfer their patient through to a waiting ambulance on the other side.

Can we imagine what it would be like to have an ambulance stopped outside of Boston and searched, under essentially gun point, for explosives or weapons and then being allowed to pass only to be searched again before entering the grounds of the Boston Medical Center to deliver the patient.

Searches are closet to the safest thing these providers face. There have been many incidents over the years of ambulances for the PRCS, the Magen David Amdam (Israeli National Ambulance), the Lebanese Red Crescent Society and other services coming under heavy fire from either militants or security personnel. Many times these services have had their ambulances used as shields by both sides, regardless of the staff or patients, from gun fire or as tools for ambush. Sometimes ambulances are specifically targeted for attack. Ambulances have also been used many times as the transport agent from the primary or secondary bombing.

I do admit that many of the differences that exist in this area of the world are political and sometimes Theological in root, but regardless of source they are at odds with the EMS systems in this area of the world.

In the history of EMS in the US can we really cite incidents where our ambulances are searched on a daily basis for fear of it being used as a bomb or to smuggle weapons? Do we know where, in the US, our ambulances have been targeted by militants or soldiers? Have they been used as shields to protect militants or soldiers regardless of EMT and patient safety? To my recollection this does not occur in this country. We are not under the same ever present threat to our patients and staffs safety and well being as these Middle Eastern EMS providers are.

So what do we disagree about: response times, number of intubation, whether private versus fire is the better model, whether to carry amiodarone or use CPAP or to establish a rehab protocol for EMS? All of these are important issues and do deserve their own discussion, but should it be that difficult to come to a consensus on how we provide EMS in the US?

When you really sit back and think about it, the differences we have between providers in the US are minor compared to what our brethren EMS providers face in the Middle East.

Maybe we should stop and think the next time we are at a meeting debating a contentious point or on the street working with other providers that our differences really aren't that insurmountable if we just take the time to talk and work together honestly for the betterment of EMS and our professions.

Telemedicine Becoming Reality for Prehospital EMS

From the [May 2007 Issue](#) of [Emergency Medical Services](#)

By [Marie Nordberg](#)

Associate Editor



Telemedicine is not a new technology. It's been around for years, although it typically hasn't received much attention. Until now. With the growing availability of broadband wireless systems, people across the country are taking notice of a technology that could change the entire face of EMS. One city with a lot of forward-thinking people is Tucson, AZ.

"We're running two pilot programs: an Alpha truck, which is a social service-type program, and the ER Link program, which is a telemedicine unit," says David Ridings, assistant chief of the Tucson Fire Department's EMS Division. "The ER Link program is a groundbreaking exercise in placing live streaming video in the back of ambulances that will transfer to local hospitals. We're still in the secondary phase of equipping all the ambulances with the video and completing the hospital equipment placement, and there is a training component for all the department's paramedics."

By the time you read this, the program should be up and running in conjunction with the University Medical Center—the regional trauma center attached to the University of Arizona. "We're going to limit the program initially to trauma and expand to medical illnesses later on," Ridings explains. "There will be a video camera on the outside of each ambulance and one in each patient compartment that will include video, audio and data transfer through a wireless mesh network from a moving ambulance to telemetry units at the trauma center via radio receivers attached to traffic signals or light poles within the city limits."

The primary advantage of this technology, says Ridings, is the ability to better prepare the hospitals for the patients they're about to receive. "The hospitals will be able to mobilize their response to trauma based upon what they see in the patient from the field," he says. "They can see and talk to the patient and view the accident scene. The live video on an accident scene will show the degree of damage to the vehicles and how that mechanism was transferred to the patients. They'll have a better look at what the paramedics are seeing in the field."

A future goal for Tucson is to add telemedicine to the already-existing Alpha truck, which responds to chronic, or frequent flyer, calls to the 9-1-1 system. "Instead of the old cycle of alcoholics and system abusers who constantly drain the system by putting demands on it, we hope to add video to the trucks and use doctors as intermediaries to acknowledge that these people don't have to come to the ED if they aren't emergent," says Ridings. "We run about 72,000 calls in Tucson a year, and approximately one-sixth, or 12,000 calls, involve nonemergent medical care, which places a huge burden on the prehospital system. Any tool we have to alleviate that problem is a benefit to us."

Why the long wait?

If telemedicine can solve so many problems, why is it taking so long to catch on? "Much of it has to do with the communications infrastructure and computing power," says Michael Smith, president of New Jersey-based General Devices, a producer of voice and data communications equipment and telemedicine systems for EMS. "Three to four years ago, mesh technology was something people were playing with. Now, those systems are being sold in most U.S. cities and will become commonplace in a few short years. More than 300 large cities have bought broadband wireless, so it comes in at a fairly reasonable cost and it's enormously powerful. Being able to have 700 kilobits per second or 2 megabits per second come out of a moving ambulance is astounding. In Tucson, that means they can be connected anywhere they want to be. With the Internet, anywhere can be literally any place in the world. Second, the cellular system has gotten much better and people are starting to see the capabilities of their cell phones that have cameras in them.

"The other factor is computational powers," Smith continues. "You can now take a PC and shrink it down to a fairly small size so it becomes a hub inside an ambulance, and that's what we've done. Our CarePoint, which is intended to address EMS needs in the emergency department, can now do the same thing in an ambulance. The applications are limitless. Because it has a powerful computer, that telemedicine system can be used to send ED status reports and handle logistical and supply issues, as well."

Because telemedicine deals with patients at a distance, it's easy to assume that its best application is in rural areas; however, technology, not distance, is what determines its use. "The issues really revolve around how long it takes to get a patient to where he's supposed to be," says Smith. "In telemedicine, that's known as the time-space barrier. We all tend to think of rural as being long transport times, but try to get an ambulance across Manhattan on a snowy day and it's no better. I don't think anyone will really know for a while where telemedicine will best serve. Stroke assessment is one area where telemedicine definitely fits, and I think it's just a matter of time before that becomes as routine within EMS as 12-lead ECGs.

"EMS leaders are beginning to realize this is coming at them whether they want it or not," Smith adds. "Even those who don't agree with the technology are beginning to see it on their radar screens. Telemedicine is the future of EMS."

A Brief History of Where We Came From

Article printed from Wikipedia.

This portion may be located at http://en.wikipedia.org/wiki/Emergency_medical_services

Emergency care in the field has been rendered in different forms since the beginning of recorded history. The New Testament contains the parable of the Good Samaritan, where a man who was beaten is cared for by a Samaritan. Luke 10:34 (NIV) - "He went to him and bandaged his wounds, pouring on oil and wine. Then he put the man on his own donkey, took him to an inn and took care of him." Also during the Middle Ages, the Knights of St. John, also known as the Knights of Malta, began to help their injured comrades, forming the basis of the modern Order of Malta Ambulance Corps and St. John Ambulance movements.

The first record of ambulances being used for emergency purposes was the use by Queen Isabella of Spain, in 1487. The Spanish army of the time was treated extremely well and attracted volunteers from across the continent, and part of this was the first military hospitals or 'ambulancias', although injured soldiers were not picked up for treatment until after the cessation of the battle, resulting in many dying on the field.

A major change in usage of ambulances in battle came about with the ambulances volantes designed by Dominique Jean Larrey (1766–1842), Napoleon Bonaparte's chief physician. Larrey was present at the battle of Spire, between the French and Prussians, and was distressed by the fact that wounded soldiers were not picked up by the numerous ambulances (which Napoleon required to be stationed two and half miles back from the scene of battle) until after hostilities had ceased, and set about developing a new ambulance system. Having decided against using the Norman system of horse litters, he settled on two- or four-wheeled horse-drawn wagons, which were used to transport fallen soldiers from the (active) battlefield after they had received early treatment in the field. These 'flying ambulances' were first used by Napoleon's Army of the Rhine in 1793. Larrey subsequently developed similar services for Napoleon's other armies, and adapted his ambulances to the conditions, including developing a litter which could be carried by a camel for a campaign in Egypt. In civilian ambulances, a major advance was made (which in future years would come to shape policy on hospitals and ambulances) with the introduction of a transport carriage for cholera patients in London during 1832. The statement on the carriage, as printed in *The Times*, said "The curative process commences the instant the patient is put in to the carriage; time is saved which can be given to the care of the patient; the patient may be driven to the hospital so speedily that the hospitals may be less numerous and located at greater distances from each other". This tenet of ambulances providing instant care, allowing hospitals to be spaced further apart, displays itself in modern emergency medical planning. The first known hospital-based ambulance service operated out of Commercial Hospital, Cincinnati, Ohio (now the Cincinnati General) by 1865. This was soon followed by other services, notably the New York service provided out of Bellvue Hospital which started in 1869 with ambulances carrying medical equipment, such as splints, a stomach pump, morphine, and brandy, reflecting contemporary medicine.

A 1948 Cadillac A. J. Miller ambulance. The A. J. Miller company purchased this car from Cadillac, then modified it to turn it into an ambulance. The resemblance to a hearse is obvious. Also in the late 19th century, the automobile was being developed, and in addition to horse-drawn models, early 20th century ambulances were powered by steam, gasoline, and electricity, reflecting the competing automotive technologies then in existence. However, the first motorized ambulance was brought into service in the last year of the 19th century, with the Michael Reese Hospital, Chicago, taking delivery of the first automobile ambulance, donated by 500 prominent local businessmen, in February 1899. This was followed in 1900 by New York City, who extolled its virtues of greater speed, more safety for the patient, faster stopping and a smoother ride. These first two automobile ambulances were electrically powered with 2hp motors on the rear axle. During World War One, further advances were made in providing care before and during transport – traction splints were introduced during World War I, and were found to have a positive effect on the morbidity and mortality of patients with leg fractures. Two-way radios became available shortly after World War I, enabling for more efficient radio dispatch of ambulances in some areas. Shortly before World War II, then, a modern ambulance carried advanced medical equipment, was staffed by a physician, and was dispatched by radio. In many locations, however, ambulances were hearses - the only available vehicle that could carry a recumbent patient - and were thus frequently run by funeral homes.

A Brief History Continued...

These vehicles, which could serve either purpose, were known as combination cars. Advances in the 1960s, especially the development of CPR & defibrillation as the standard form of care for out-of-hospital cardiac arrest, along with new pharmaceuticals, led to changes in the tasks of the ambulances. In Ireland, a mobile coronary care ambulance successfully resuscitated patients using these technologies; and well-developed studies demonstrated the need for overhauling ambulance services. One well-known report in the USA during that time was *Accidental Death and Disability: The Neglected Disease of Modern Society*. This report is commonly known as *The White Paper*. These studies, along with the White Paper report, placed pressure on governments to improve emergency care in general, including the care provided by ambulance services. Part of the result was the creation of standards in ambulance construction concerning the internal height of the patient care area (to allow for an attendant to continue to care for the patient during transport), in the equipment (and thus weight) that an ambulance had to carry, and several other factors. Few, or perhaps none, of the then-available ambulances could meet these standards.

The next newsletter will include another article looking at the History of EMS.

Annual MBEMSC Call for Nominations

Beginning April 4th the MBEMSC will be sending letters out for our annual call for nomination of candidates for membership to the Board of Directors of the Metropolitan Boston Emergency Medical Services Council, Inc. and its standing committees.

The Council is obligated to disseminate a Call for Board Member Nominations to a broad audience annually. We seek, through this process, to identify candidates to succeed those members whose term has expired or who no longer wish to serve as a member of the Board. If you want more information, contact the Region IV EMS office at (781) 505-4367.

Maintain a Healthy State of Mind



Everyone has their own ways of dealing with stressful situations. Resilience—the ability to adapt well to life’s ups and downs—can help manage stress and feelings of anxiety. Everyone can develop resilience. It involves thoughts and actions that can be learned and practiced over time.

Anyone who experiences a disaster is affected by it, whether directly or indirectly through location, family or friends, or exposure to media coverage of the event.

Even if a disaster, such as a terrorist act, produces little physical damage, it can bring fear, confusion, and uncertainty into daily life. Strong and varied emotional reactions to such an event are natural. People are resilient and able to recover from difficult experiences.

Given the uncontrollable nature of disasters, some people question whether they can take steps to plan for catastrophic events. Actually, we know that the more people prepare for the unexpected, the better they manage these situations.

The following areas are covered on the CDC website: Parents and Caregivers, Middle School Students, High School Students, Adults, Seniors. The website covers common reactions to disasters and how people in different age groups can prepare for, respond to, and recover from their experiences. This resource, and others, can be located at <http://emergency.cdc.gov/preparedness/mind>

Committee Updates

Medical Control

The MCC will begin looking at the BLS side of pre-hospital care as well as possible Protocol changes. Upcoming Meetings: 5/2/08, 7/11/08 and 9/5/08

PIER

The PIER Committee is developing several powerpoint programs for providers to use for public education purposes. Upcoming Meetings: 5/16/08, 7/18/08 and 9/26/08

Pre-Hospital Committee

The PHSCC is looking at purchasing a tabletop training kit for services to use on a lend/loan basis. Upcoming Meetings: 4/16/08, 6/18/08 and 8/20/08

Executive Committee

Currently working on the implementation of the Strategic Plan. Upcoming Meetings: 4/3/08, 6/5/08, and 7/10/08

Board of Directors

The Board of Directors will be discussing EMD at their next meeting along with other interesting topics. Upcoming Meetings: 3/21/08 and 6/20/08

Trauma Systems Committee

Has been recently re-activated under Dr. Michael Murphy and is working with DPH on Trauma Registry requirements.



From the Editor

I hope you have enjoyed our Winter/Spring 2008 edition of the Region IV News. It is our hope to continue to bring you several newsletters a year updating you on the happenings in EMS around the Region, State, Country, and World. If you have any comments or suggestions for topics, please let us know.

It is our intent each issue to allow you, the reader, to be able to submit a brief “**Express Yourself**” article for the newsletter. If you are interested in providing some form of brief article the submission guidelines are as follows:

- 1) Articles cannot be longer than 1 page, Times New Roman, 12 point font
- 2) Articles must have a title
- 3) Author, credentials and employer must be included
- 4) Articles must be thought provoking and encourage thought into the state of the global EMS system (articles must not attack, deface, or accuse other agencies, entities or providers).

These articles are designed to raise the individual providers consciousness of the complexities of our profession and the EMS system, and by doing so, inspiring many more providers to get involved in defining and refining their profession for the future.

All submissions for “**Express Yourself**” or any questions or suggestions should be emailed to dcongdon@mbemsc.org.

Until next time, be safe.

Derrick Congdon