

IDAHO EMSPC MEETING MINUTES

February 10, 2012

A meeting of the Idaho Emergency Medical Services Physician Commission was held on this date at Ada County Paramedics, 370 Benjamin, Boise, Idaho, 83709.

Members Present:

Adam Deutchman, M.D.*
Curtis Sandy, M.D.
David Kim, M.D.
Eric Chun, M.D.*
James Alter
Maurice Masar, M.D.
Murry Sturkie, D.O.

Member's Position:

American College of Surgeons Committee on Trauma
State Board of Medicine
Idaho Medical Association
Idaho Fire Chiefs Association
Citizen Representative
Idaho Association of Counties
American College of Emergency Physicians, Idaho Chapter

*attended via teleconference

Members Absent:

Keith Sivertson, M.D.
Sarah Curtin, M.D.

Member's Position:

Idaho Hospital Association
Idaho EMS Bureau

Vacant Seats:

American Academy of Pediatrics, Idaho Chapter
Citizen Representative

Others Present:

Bill Arsenault
Chris Bruce
Chris Stoker
Dave Reynolds
Dean Neufeld
Denise Gill
Diana Hone
Greg Owen
Jan Peterson
Jill Hiller
Marc Essary
Mark Johnson
Matt Conklin
Melonie Skiftun
Randy Howell
Randy Sutton
Roger Jones
Season Woods
Steve Hill
Tawni Newton
Wayne Denny

Other's Position:

Wildland Fire
Bear Lake EMS
Idaho EMS Bureau Standards & Compliance Section Manager
Moscow Ambulance
Idaho EMS Bureau Licensing Supervisor
Gooding County EMS
Idaho EMS Bureau Administrative Assistant
Canyon County Ambulance District
Bureau of Land Management
Cascade Rural Fire/EMS
Air St. Lukes
INL
Life Flight Network
Donnelly Fire
Boise Fire Department
West End Fire & Rescue
Bear Lake EMS
Idaho EMS Bureau Education & Exams Specialist
Bear Lake EMS
Idaho EMS Bureau Investigations
Idaho EMS Bureau Chief

Chairman Sturkie called the meeting to order at 8:33 a.m.

**Commissioner Kim, Idaho Medical Association, moved and Commissioner Sandy, State Board of Medicine, seconded the motion to go into closed executive session to review confidential material involving EMS personnel in accordance with Idaho Code § 67-2345(1)(b).
Motion passed unanimously.**

**Commissioner Masar, Idaho Association of Counties, moved to come out of executive session.
Commissioner Alter, Citizen Representative, seconded the motion.
Motion passed unanimously.**

Chairman Sturkie welcomed the audience back into the room.

Approval of Minutes from 11-18-11

**Commissioner Sandy, State Board of Medicine, moved and Commissioner Masar, Idaho Association of Counties, seconded the motion to accept the draft minutes as submitted.
Motion passed unanimously.**

License Action Report

**Commissioner Masar, Idaho Association of Counties, moved to accept actions taken in closed session.
Commissioner Alter, Citizen Representative, seconded the motion.
Motion passed unanimously.**

Medical Director Education Report

Subcommittee Chairman Alter reported that the EMS Bureau has identified five (5) counties to pilot the new medical director education training model. The Bureau is in the process of determining local unit meeting dates for these areas and their primary concerns. At least one (1) EMS Physician Commissioner and one (1) EMS Bureau representative would attend the meeting. They would cover the roles of an EMS medical director, current concerns, and end with an open forum question and answer period. It is hoped that the medical directors, agency administrators and other interested EMS providers would attend. The subcommittee intends to reach out to areas where medical directors have not attended medical director workshops before. They want to be able to give very specific agency or system guidance and get medical director to medical director discussions going. Chairman Sturkie suggested taking this to regional conferences and having a break out session.

Medical Supervision Plan Subcommittee

Subcommittee Chairman Deutchman reported that the subcommittee has stalled since their last approach using a targeted questionnaire was scuttled. They need new consensus and direction from the Commission. Commissioners do not want medical directors to simply list the medical supervision plan (MSP) requirements stated in rule and say they are going to do them. The Commission wants to know the process they are going to use to fulfill the requirements: who, what, when, and how. The problem still lies in the fact that the EMSPC does not have the resources to evaluate the MSPs and give feedback.

Commissioner Kim, Idaho Medical Association, moved to reconstitute the Medical Supervision Plan Subcommittee with a new chair and new members and to charge them with reviewing the medical supervision plan requirements and identifying ways to improve the creation and submission of medical supervision plans. Commissioner Sandy, State Board of Medicine, seconded.

The difficulty in developing a template that meets the needs of very diverse agencies throughout the state was discussed again. Chairman Sturkie suggested creating an instruction manual such as the one used for the EMS grant application process. The instruction manual would explain each requirement and give examples. The

Commission would periodically request a few MSPs to be reviewed. Commissioners felt this was a good idea, but it still does not address the problem of how the EMSPC would provide feedback in a timely manner. Without an evaluation tool or standard, the evaluations become subjective and are very time consuming. What is the standard? What is the minimum that is acceptable?

Commissioner Sandy expressed concern that as EMS moves forward the gap between medical directors who are Board Certified in EMS and those that are not board certified is going to grow. He feels it is the EMSPC's responsibility to try to fill that gap. There must be a basic fund of knowledge and level of performance that all EMS medical directors have, even though they are not all Board Certified in EMS. That is why going through the process of spelling out their MSP is really important. The Commission needs to make sure EMS medical directors know what they are signing up for. Liability is going up, litigation is increasing.

Randy Howell asked that "Best Practice" MSPs be posted on the website for examples.

Motion passed unanimously.

Commissioner Sandy, State Board of Medicine, moved to postpone formation of a new Medical Supervision Plan Subcommittee until after the Medical Director Education and Statewide Protocol Subcommittees have completed their projects. Commissioner Masar, Idaho Association of Counties, seconded.

In favor: Masar, Sandy, Deutchman

Opposed: Kim, Alter, Sturkie

Motion failed for lack of majority.

Chairman Sturkie asked Commissioner Masar if he would be the new chair of the Medical Supervision Plan Subcommittee. Commissioner Masar agreed.

ISFCA Presentation Report

Commissioner Sandy reported that the presentation he made to the Idaho State Fire Commissioners Association in November went really well. His presentation was about 30 minutes long and focused mainly on medical director education and the development of statewide protocols, with a question and answer period at the end. They expressed appreciation for keeping them in the loop with a visit from an actual medical director/commissioner. As fire districts, they feel disconnected from their medical directors since the transport agencies control them. Commissioner Sandy felt this was definitely a good opportunity to meet with stakeholders and recommended the Commission continue the outreach to other associations.

Statewide Protocol Subcommittee Report

The subcommittee just completed a three day retreat. Subcommittee Chairman Kim reported that they spent 31 hours working on protocols and procedures in the windowless EMS Bureau basement bunker. The subcommittee hopes to be able to submit a complete set of protocols and accompanying procedures to the EMSPC for approval at the May 2012 meeting. There is a 50% chance of that happening. The subcommittee focused on content and the bureau liaison, Dean Neufeld, will now address the formatting issues. There are drafts of every protocol even though some are still very rough.

Commissioner Kim acknowledged the participation and expressed appreciation for Dave Reynolds, Commissioner Sandy, Dean Neufeld, Commissioner Sivertson and Tom McLean.

Commissioner Kim, Idaho Medical Association, moved that the EMS Physician Commission commits itself as the subject matter and content expert for the development and maintenance of Statewide EMS Protocols and Procedures that shall guide the care of patients by licensed EMS personnel and EMS agencies in Idaho. Commissioner Sandy, State Board of Medicine, and Commissioner Masar, Idaho Association of Counties, seconded.

Motion passed unanimously.

Commissioner Kim, Idaho Medical Association, moved that the Commission recommends that the EMS Bureau provides support to the EMSPC to create, maintain, and revise, on a periodic and as needed basis, the Commission's Statewide EMS Protocols and Procedures. The EMS Bureau should allocate sufficient resources to distribute the EMSPC Statewide EMS Protocols and Procedures. Commissioner Sandy, State Board of Medicine, seconded.

Motion passed unanimously.

Commissioner Kim, Idaho Medical Association, moved that the Commission modify its rules by inclusion of the following new section:

“16.02.02.100.03. Statewide EMS Protocols & Procedures.

- a. The Commission will generate Statewide Protocols and Procedures and review them as necessary and at a minimum of every two (2) years.**
- b. The patient care provided by licensed EMS personnel and EMS agencies must conform to the Commission's Statewide Protocols and Procedures unless specifically exempted by the Commission.”**

Commissioner Sandy, State Board of Medicine, seconded.

Motion passed unanimously.

Randy Howell asked what impact “Statewide Protocols” would have on individual agencies. Will everyone be expected to transition to these Statewide Protocols or are they a guideline? Commissioner Kim responded that use of the Statewide Protocols and Procedures will be mandatory as stated in the proposed rule change. An agency must receive specific exemption from the Commission if they want to use something else. The idea is that if an agency has an engaged medical director, with off-line medical direction, on-going development of protocols and procedures, etc., they can apply for an exemption. The EMSPC will allow agencies with robust medical oversight the ability to use their own locally developed product. However, he feels agencies across the state will be very happy with the Statewide Protocols and Procedures. The subcommittee is working hard to make them very contemporary and progressive.

Chairman Sturkie expressed appreciation to the subcommittee for all of the hours and hard work.

Optional Module Tracking – What does the EMSPC want to know?

The Bureau is attempting to streamline the optional module (OM) process for agencies and the Bureau. As part of this process, the Bureau requested clarification regarding what information the Commission needs and wants regarding OMs.

Commissioners want to know:

1. Which agencies, what level, how many are actually approved/authorized to use OMs?
2. Are they actually using them?
3. Number of times each OM is actually used.

Example: Out of X number of ILS agencies, how many are approved to use OMs and how many are actually using them?

It was suggested that perhaps a line could be added to the agency license renewal applications regarding OM usage. Agencies would indicate what they are currently doing regarding OMs since an agency may apply for authorization to use OMs and then over time decide not to allow their use, which may not be reported to the bureau.

2013 Standards Manual Changes

Removal of Impedance Threshold Device

A request was made by one of the commissioners to discuss removing the impedance threshold device (ITD) as an OM from the scope of practice. Since that request in November, it was found that some of the study reports regarding the use of ITDs are being revamped. Therefore, it may be premature to discuss this topic at this time.

Commissioner Sandy, State Board of Medicine, moved to table the discussion of removing impedance threshold devices as optional modules from the scope of practice until an undetermined future date.

Commissioner Masar, Idaho Association of Counties, seconded.

Motion passed unanimously.

AEMT-85 Description of the Profession Language in Section VIII of the Standards Manual

Currently each provider is built upon the scope of practice of the previous provider level, but there is now a disconnect in the description for the AEMT-85 since they will not have the full skill set of EMT-2011s.

It was determined to defer this discussion until after the EMSPC decides what they are going to do about AEMT-85 options listed later on the agenda.

Expanded Scope of Practice for Epi IM

Because it is extremely expensive to stock each EMS unit with EpiPen Auto Injectors and they expire on an annual basis, it has been suggested that the EMSPC look at extending epinephrine intramuscular injections as an optional module to EMTs. After discussion:

Commissioner Masar, Idaho Association of Counties, moved to make Epi IM a 2,4,OM for all EMRs, EMTs and AEMT-85s. Commissioner Sandy, State Board of Medicine, seconded.

Motion passed unanimously.

The Commission will create a protocol, possibly with a one dose vial or a smaller needle that would only draw one dose.

Gooding County Variance

Denise Gill presented the commissioners with data from the last five (5) years regarding Gooding County EMS AEMT's use of their expanded scope which includes sublingual nitroglycerin, EpiPen auto injector kits, aspirin, dextrose-50, and albuterol. The usage rate has remained about the same. 10% of the patients they transport receive one or more of these interventions.

This started about 12 years ago when the Board of Medicine approved Gooding County EMS to start using these skills to see how effective they would be in the rural communities. The new AEMT-2011 scope will include all of these skills.

Gooding County EMS asked for another two (2) year extension of their variance while they transition their current AEMT-85s to the new AEMT-2011 level.

Commissioner Sandy, State Board of Medicine, moved to continue the Gooding County EMS variance for the expanded scope of practice for two (2) more years with expectation of transition to the new AEMT-2011 scope. Commissioner Alter, Citizen Representative, seconded.

In favor: Sturkie, Alter, Kim, Sandy, Deutchman

Opposed: Masar

Motion passed.

This led to a discussion to clarify the scope of practice grid regarding inhaled beta agonist using MDI or a nebulizer. It was determined that the scope of practice grid should be clarified.

Commissioner Kim, Idaho Medical Association, moved to modify Line 139 for Inhaled Beta Agonist to include (MDI) and add a new line to include SVN which would be X in EMT-2011, X for AEMT-2011 and X in Paramedic-98 and Paramedic-2011. Commissioner Sandy, State Board of Medicine, seconded. Motion passed unanimously.**

Chairman Sturkie felt the terms “MDI” and “SVN” may need to be addressed to allow for terminology changes in the future.

Nitroglycerin (paste) will be discussed at the May EMSPC meeting.

Operational Specific Scopes of Practice

Commissioner Sandy would like the EMS Physician Commission to either develop operational scopes of practice for individual entities such as wilderness, tactical, hazmat, etc., or allow those organizations to present to the Commission for variance waivers with scopes of practice. From a time standpoint he feels it would be easier to develop operational scopes and allow organizations to apply for them. They would be treated much like an optional module with intense medical oversight, intense specific approved training, and credentialing.

Commissioner Sandy explained that there is a perceived need for certain levels of care to be provided in certain situations. If that need is not met through EMS licensure, they will seek outside resources and relief such as Outdoor Emergency Care (OEC) with exemption or other national certifications such as the Wilderness First Responder. These are not recognized as EMS certifications and therefore the state has no oversight. The EMSPC has no control over a wilderness first responder’s scope of practice, even though their current scope includes prescription and over-the-counter medications.

Bureau Chief Wayne Denny responded that without a definition of EMS in law the EMSPC or Bureau could not compel someone who self declares they are not performing EMS. Many say, “I am not an EMT, I am not billing for my services, I am not operating in the EMS system, or I am not part of it because I do not transport.”

Commissioner Sandy agreed that is a problem with outsiders, but his main focus is licensed EMS personnel and agencies. They have EMS agency licensure, they have EMS licensed personnel, they have a medical director, they have an MSP and everything else, but because of the situation in which they operate they would like to have an operationally specific scope of practice. IV therapy for fluid administration and dehydration is probably one of the biggest needs. The use of prednisone or Benadryl to help with prolonged allergic reactions, rather than just the EpiPen, is another one. Wilderness First Responders are taught to carry and use these right now. But a licensed EMT, or even an AEMT who can do the IV, can’t administer Benadryl.

Commissioner Sandy will draft some specific proposals for skills and medications involved.

EMT 2011 / AEMT 85 Options

Because the Commission promised in May of 2008 that the AEMT-85s would not be required to transition to the new Idaho education standards and scope of practice when it moved to one based on the National Education Standards, the Bureau and Commission continue to struggle with resolving the unintended consequences.

One of the issues is transfer of care from an EMT-2011 who will have floor skills that an AEMT-85 will not have such as: Aspirin for suspected cardiac chest pain (even though it is AEMT-85 OM), ATV for non-intubated patients, Epi-Auto Injector (also an AEMT-85 OM), MARK-1 Duo Dote, and Pulse Oximetry (AEMT-85 OM). The differences are minimal but the question is, "Do we leave the AEMT-85 as a frozen scope of practice, leaving in question the transfer of care from an EMT-2011?" This also creates a problem with the progression of care from EMT to AEMT as described in the Description of Profession in the standards manual as stated earlier in the meeting.

The possibility of allowing EMT-2011s to have some of the current AEMT-85 skills as optional modules to retain these skills for patient care in areas that are not going to transition to the new AEMT-2011 scope of practice was discussed again at length. Chairman Sturkie asked the audience if they were interested in seeing the EMT-2011s get IV, IO and Supraglottic Airways as optional modules. Would they be useful and how often did they think they would use them. Some of the comments are listed below:

Commissioner Masar – Some AEMT-85s tell him they are not interested in transitioning because they are getting older and don't know if they want to put the extra time into it at this point.

Bill Arsenault - It certainly has benefit in the wildland community. Many individuals now applying to federal agencies have been trained by the military as EMT-Basics. They are coming into the wildland programs with a certain set of valuable skills for providing care to folks with long distance, extended transport times, but they are limited in what they can do by the EMSPC scope of practice. I think giving these skills, with proper training and proper oversight, to EMTs would be beneficial to the wildland community.

Randy Sutton - West End Fire & Rescue - Yes, having IV access as an OM for the EMT would be an asset to us due to deterioration of the patient over long transport times. We are sitting out in an area in southern Idaho where it takes 35 minutes to get a transport ambulance to us.

Melanie Skiftun – Donnelly Fire - Another problem agencies have is because of volunteers. Everyone is working and strapped for time anyway and then to try to put these additional hours on them to transition, we have people say they are not going to do it. So having them as an OM for EMTs would be good.

Steve Hill - Bear Lake EMS – I am an I-85 right now and my concern about going to the AEMT-2011 isn't necessarily that I am getting older. I am looking at it from the agency standpoint because it requires a whole additional set of materials that need to be stocked on the ambulances that expire. There will be added expense to upgrade, not just the training, but the extra supplies for AEMT-2011. We have to ask if this is something our agency is willing to go to. I am willing to go through the training, but is it something our service can support after we get that training?

He stated that if the Commission allows these OMs for the EMT-2011 he would also like to see IO and CPAP included. If those were available he would be in transition right now to EMT-2011 because that eliminates the quandary. If IO and CPAP were also available as EMT-2011 OMs, the AEMT-85 would either go up to AEMT-2011 or go laterally to EMT-2011 with the same skill set they already have. You don't lose anything.

Sturkie mentioned that the “Advanced” title is important to some people.

Steve Hill asked, “If an AEMT-85 transitions to EMT-2011 w/OMs, could they still “transition” to AEMT-2011 later rather than take the entire AEMT-2011 course?” Answer: Yes, as long as you do it before your AEMT-85 expires. Furthermore, because both initial and transition Idaho EMS Curriculum (IEC) courses are competency based, even if you had to enroll in an initial AEMT-2011 course it should not take long to prove competency. You may not have to take the entire initial class.

Some other states do allow EMTs IV Access and Advanced Airway.

Season Woods – What about the Medicaid / Medicare billing question?

Chairman Sturkie – Yes, if it becomes a BLS skill, even as an OM, it is always billed at the Medicaid BLS level, even when an ALS agency performs the skill.

Dave Reynolds – Moscow Ambulance - As a representative of his area he was asked to share that they want everything simplified, not more complicated. They would like all OMs eliminated from the grid. They feel as volunteers that they struggle to meet call volumes and continuing education, and that they are totally overwhelmed by pages of grids, optional modules, different scopes, different licensure levels, and different agency levels. They are quite frustrated.

Chairman Sturkie – if we simplified it by making all OMs part of the floor, that would actually impose a greater obligation to all providers to meet increased training time and expense. That is why it is complicated. We leave it as optional to add as much leeway to individuals and agencies as possible. They can determine how much time and energy they want to put into this without compromising other agencies.

The pros and cons for each skill were discussed at length including the need for training, oversight, and competency maintenance.

Chairman Sturkie asked Commissioner Deutchman, as the representative of the American College of Surgeons Committee on Trauma, what his feelings were about supraglottic airway and IV fluids in the field.

Commissioner Deutchman responded that supraglottic devices are being taught in ATLS to the physicians and over the last few years to non-physician practitioners, such as nurse practitioners and PAs, as well. Likewise, the IO has been an adjunct that is becoming more ubiquitous, and certainly in the theatre of battle, it is being used more ubiquitously by minimally trained individuals. I think that it is fair to include these skill sets. He agrees that simplification makes sense from an administrative standpoint, but over the years of trying to calibrate what the needs are, he sees that one size does not fit all. He, therefore, leans towards maintaining OMs.

Commissioner Kim said that he is torn too, because he is not a big fan of skill-creep and the maze of OMs in the grids. At this moment if a vote were taken, he would vote in favor of adding IV and IO to the EMT-2011, but would vote against the Supraglottic Airway. He is concerned that there is not enough data saying it is as benign as we think it is. He was in favor of taking intubation away from the AEMT partly because, if they are not going to intubate, they can at least put in a supraglottic blind insertion airway device. The difference in this scenario is the AEMTs already had supraglottic airway, but EMT-2011s don't. Therefore, he feels it is a bit premature, with the amount of data out there right now, to expand those supraglottic airways to another level of provider. He would prefer to revisit this once there is additional research. It is a very different scenario from what the Commission did with the AEMT intubation.

In terms of data, Commissioner Kim asked, “How many lives are we going to save?” He requested the Bureau provide a map or grid to show geographically what proportion of the state is covered by AEMTs today, or what percentage of the population of Idaho is covered by AEMT-85s versus EMTs to see if we are really going to have an impact on the well being of Idahoans with this decision. Tawni Taylor noted that the ILS rule does not

require an AEMT go on every call like at the ALS level. A lot of agencies are losing their AEMT-85s through attrition so they are not available for every call.

Chairman Sturkie stated that he is in favor of all three (3) OMs, but would be interested to see the grid of where the impact would be across the state and areas that don't have any ILS at all.

Greg Owen – Canyon County Ambulance District – Objects to all of the proposed EMT-2011 OMs if it means charging for these skills at the BLS reimbursement rate rather than ALS. He feels the Commission needs to realize that what they are offering to BLS agencies may not be beneficial, but it will negatively impact the ALS agencies that actually use them.

Commissioner Alter, Citizen Representative, moved to table the discussion regarding EMT-2011 Optional Modules and discuss it further at the next meeting. Commissioner Masar, Idaho Association of Counties, seconded.

Motion passed unanimously.

Chairman Sturkie, American College of Emergency Physicians, Idaho Chapter, moved to allow AEMT-85 to take the EMT-2011 transition course to acquire the additional EMT-2011 skills and still maintain licensure as AEMT-85. Commissioner Alter, Citizen Representative, seconded.

Motion passed unanimously.

It has been determined by the Bureau that Finger Sweep, Modified Chin Lift, and Hemorrhage Control – Dressing actually were included in the old curriculum, but the lines were not on the Idaho EMSPC scope of practice grid. Those lines were added when the new 2011 curriculum columns were added. Xs need to be put in the orange boxes on the grid.

Align Rule Text (16.02.02.400 & 500) with changes made regarding Medical Supervision Plan Submission Requirements in the 2012-1 EMSPC Standards Manual

Chairman Sturkie, American College of Emergency Physicians, Idaho Chapter, moved to change wording in 16.02.02. Rules of the Idaho Emergency Medical Services (EMS) Physician Commission to align with changes made in 2012-1 Standards Manual regarding medical supervision plan submission as follows:

16.02.02.400.07 Out-of-Hospital Medical Supervision Plan Filed with EMS Bureau. The agency EMS medical director must ~~file~~ submit the medical supervision plan within thirty (30) days of request, ~~including identification of the EMS medical director and any designated clinicians~~ to the EMS Bureau in a form described in the standards manual.

a. The agency EMS medical director must identify the designated clinicians to the EMS Bureau annually in a form described in the standards manual.

a.b. The agency EMS medical director must inform the EMS Bureau of any changes in designated clinicians or of a change in the agency medical director ~~the medical supervision plan~~ within thirty (30) days of the change(s).

b.c. The EMS Bureau must provide the Commission with the medical supervision plans ~~annually and upon~~ within thirty (30) days of request.

e.d. The EMS Bureau must provide the Commission with the identification of EMS Medical directors and designated clinicians annually and upon request.

16.02.02.500.09 Medical Supervision Plan. The medical supervision of licensed EMS personnel must be provided in accordance with a documented medical supervision plan.

The hospital supervising physician or medical clinic supervising physician is responsible for developing, implementing, and overseeing the medical supervision plan, and must submit the plan(s) upon within thirty (30) days of request of the Commission or the EMS Bureau.

**Commissioner Kim, Idaho Medical Association, seconded.
Motion passed unanimously.**

**Chairman Sturkie, American College of Emergency Physicians, Idaho Chapter, moved to approve the PARF to initiate rulemaking. Commissioner Masar, Idaho Association of Counties, seconded.
Motion passed unanimously.**

Strategic Plan

Commissioner Kim asked the Bureau to create some sort of dashboard or grid that shows EMS statistics that should be reviewed periodically or annually such as: number of medical directors, number of agencies and what type, how many personnel at each level, how many responses, how many personnel opted not to renew licensure, how many have transitioned already, etc.

**Commissioner Kim, Idaho Medical Association, moved to adjourn. Commissioner Alter, Citizen Representative, seconded.
Motion passed unanimously.**

Adjournment 3:30 pm

Murry Sturkie, Chairman
Idaho Emergency Medical Services Physician Commission