

OPEN MEETING MINUTES

Instructions: [F-01922A](#)

Name of Governmental Body: Emergency Medical Services Board			Attending: Jerry Biggart, Mark Fredrickson, Gary Weiss, Christopher Anderson, M. Riccardo Colella, Steven Zils, Carrie Meier, Don Kimlicka, Michael Clark, Dustin Ridings, James Newlun, Ray Lemke, Chuck Happel, Mark Mandler, and Sandy Ryce
Date: 12/5/2017	Time Started: 9:02 AM	Time Ended: 5:00 PM	
Location: Madison Marriott West, 1313 John Q Hammons Dr, Salon D, Middleton, WI 53562			Presiding Officer: Jerry Biggart

Minutes

1. Welcome and Committee Member Check-in. Meeting was called to order at 9:02 AM.
2. Public Comment Opportunity on Board agenda or special announcements. Paul Krupski was on the agenda for tomorrow but is unable to attend. He is here today. Paul is the new Director of Opioid Initiatives in the Secretary's office at DHS. The new position was created based on a signed order from the Governor as part of the opioid task force. Paul's main role is to coordinate the grants for treatment, prevention and recovery. Paul asked for feedback from the Board. He is willing to come to future meetings to do a presentation, provide data on the opioid crisis, etc. Carrie asked for opioid data from the epidemiologist. The opioid epidemiologist position is currently open and DHS is going to fill that position in 2018. Jerry will get in touch with Paul directly to discuss data relating to the opioid crisis.
3. **Motion by Gary Weiss, second by Dustin Ridings to approve the minutes of the October 17th and 18th meeting. Motion carried unanimously.**
4. Clarify a Technical Record of the Voting Members of the Physician's Advisory Committee. The state Medical Director is listed as a voting member of PAC and she is not. Also, Dr. Colella is not listed as a voting member. The board would like to clarify that Dr. Colella did express an interest in being on the PAC to Jerry Biggart. New members must complete an application; current members just need to express an interest on staying on the PAC as a member.
Motion by Gary Weiss, second by Mark Fredrickson to have Dr. Colella be added to the list of the voting members of PAC. Motion carried unanimously.
5. Standing EMS Committee - System Quality & Data (Carrie Meier/Chair)
 - a. Roll Call of Committee Members: Carrie Meier, Cami Thalacker, Christoph Walters, Daniel Morth, and Martin Rukavina.
 - b. Carrie asked for suggestions on what to do with the data that is being collected through WARDS Elite.
 - c. Review Interfacility versus 911 Data and provide recommendation and possible vote.
A report featuring the 2017 interfacility vs. 911 responses for each region/month was discussed. Suzanne Martens pointed out that the interfacility transfers (unscheduled) should be higher. A communication may need to be sent to services to be sure the reporting of these is accurate. It was suggested to have the report broken down by county. This is to identify how long unstable patients are being transported for. Then questions need to be raised on what to do with this data. Some of the fields in WARDS will need to be renamed to ensure accuracy. James informed about a grant application for \$75,000 from the DOT to utilize the funds to provide training statewide to EMS services on WARD Elite and what information goes into reports. Steve Zils asked about the data dictionary. Dave from Image Trend is working on gathering this information to define the fields that are listed in Elite. There is currently a NEMESIS dictionary on the DHS website.

However, it is over 700 pages long. Carrie asked Chuck to pull primary impression data for the next report. Carrie asked for a priority to be placed on primary impression-cardiac arrest. This information will assist with a determination on whether we should use the CARES registry. This report was requested for the EMS Board to receive at least two weeks before the next meeting.

Carrie Meier, James Newlun and Jenny Ullsvik will set up a meeting to discuss what is in legislation that protects the CQI from being discoverable. This meeting will be before the February Board meeting.

- d. Review the Current Status of the WARDS Elite Transition. There are 35 transporting services that do not have reports in Elite. An email communication was sent to all of these services to begin reporting. This was the final attempt to reach out to the services to get this taken care of. After this, a warning will be sent. Operational plans will not be approved if a service is not reporting. By next week, the email communication that was sent to those services will be sent to RTAC coordinators. After that a reprimand will be sent to those services not reporting, followed by a conditional license, and revocation. The list of services not reporting will be communicated with the medical directors of those services as well as the EMS Board.
6. Standing EMS Committee – Education & Training (Greg West/Chair)
 - a. Roll Call of Committee Member: Brian Litza, Jeff Matcha, Sean Duffey, Kelly Bechel and Tim Weir.
 - b. Discuss Impact of Increasing Mandatory Scope of Practice Items on Educational Hours and provide recommendation and possible vote. James asked the committee to keep in mind that additions to the scope of practice and the hours keep getting added for the training. Discussion followed. One point was that with the opioid crisis, all kinds of people are administering Naloxone. Also, wound packing and tourniquets are part of this. Another point was made that some services are thinking of downgrading from paramedic to intermediate because of all the additions to the scope of practice for intermediate.
Motion by Brian Litza, second by Jeff Matcha to have Wisconsin continue to maintain the national standards and scope of practice as they are updated. Brian made an amendment to have the curriculum meet the minimum training. Jeff was ok with the amendment. Motion carried unanimously.
 - c. Discuss Status of Training Center Operational Plan Template in E-licensing and provide recommendation and possible vote. Mark Fredrickson asked about an application that submitted a request to become a new training center. The state office requested a letter of recommendation that the training center be created. They want to know why the recommendation letter was requested. Ray Lemke provided information about the administrative rule requirement is to show a need for that training center to be added. James mentioned that the flexible refresher option allows a service to train their own personnel with Medical Director approval without becoming a training center. This will need to be discussed further tomorrow because of time constraints today.
 - d. Discuss Paramedic Instructor Qualification for Lead Instruction of a Critical Care Paramedic Course and provide recommendation and possible vote. Concerns were discussed. Ray Lemke provided information from administrative rule 110.28 regarding Instructor II requirements. James will look into administrative rule further to provide clarification. Jerry asked for an expedient response due to some upcoming courses.
 - e. Adjourn
 7. EMS for Children Meeting with the EMS Board (Dr. Kim/Dr. Browne/Chair)
 - a. Roll Call of EMSC and Board:
Michael Kim, Lorin Browne, Riccardo Colella, Erica Kane, Melanie Mulhall, Dusting Ridings, Andrew Werth, Brook Lerner, Patrick Drayna, Jason Selwitschka, James Newlun
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- a. Approval of June, August, and October minutes: **Lorin Browne made a motion to approve the minutes and Melanie Mulhall seconded. Motion carried unanimously.**
 - b. Discuss status of DHS 118: DHS Legal has returned edits to DHS 118 to Caitlin Washburn. Public hearings are expected in 2018.
 - c. Discuss EMSC advisory committee vacancies: Matt Pineseault has accepted the EMS Representative position on the EMSC Advisory Committee. The Hospital Representative position, previously held by Heather Godemann, is currently vacant. EMSC Advisory Committee members are encouraged to share the vacancy listing with their hospital contacts. Revising the vacancy listing to require clinical experience was discussed, but a vote was not held.
 - d. Discuss next steps for EMS survey data: Preliminary survey data from EMS agencies regarding EMSC Performance Measure 02 and 03 was shared. 21% of agencies surveyed have a pediatric emergency care coordinator in place and 22% had policies to require physical demonstration of pediatric-specific equipment. Several questions were raised regarding the specific wording of the survey. Detailed information regarding survey methods and results will be shared at the February meeting.
 - e. Discuss HRSA notice of funding opportunity: EMSC HRSA grant application is due on January 8, 2018. DHS and the Children's Health Alliance of Wisconsin (CHAW) will collaborate to complete the application. HRSA anticipates that current funding levels will be maintained for the 2018-2022 grant cycle. Funding for FY 2017 will cover WI EMSC through February 28, 2018. FY 2018 funding will not begin until April 1, 2018, leading to a one month funding gap. CHAW and DHS collaborate to ensure continuity of EMSC through the unfunded month, March 2018.
 - f. Review education plan and web outreach: Pediatric online training for pre-hospital providers with voiceover and interactive features was discussed. Online modules will be designed to align with flexible refresher requirements for EMS. WITRAIN will be used to house the online training modules. CHAW is redesigning their website, which will impact the EMSC page. Two to four Advisory Committee members will be requested to review web resources and links, and suggest updates.
 - g. Discuss EIIC Pediatric Readiness Quality Collaborative: WI EMSC was not able to secure commitment from our two WI based children's hospitals, American Family Children's Hospital (AFCH) and Children's Hospital of Wisconsin (CHW), to serve as training sites. WI affiliate hospitals are still eligible for participation and will be matched with out-of-state training sites. Independent of the PRQC, WI EMSC will continue to pursue opportunities to advance pediatric readiness through funding and continued collaboration with WI hospitals.
 - h. Review EMSC data report: WARDS Elite pediatric data related to transport destination, top five primary impressions, top five causes of injury and total ambulance runs was reviewed. WARDS Elite uses ICD 10 code as the basis for primary impression. There are multiple ICD 10 codes that relate to specific illness and injury, which has resulted in very granular data categories. The EMS Data Committee will continue to discuss techniques to make this data most useful.
 - i. Discuss emergency care for children with special needs and the PAR database: Effective February 1, 2018, the PAR database will be taken off line. Without additional dedicated funding, database rebuild is not feasible. All registered PAR users will be notified of the shutdown. Parents were instructed to provide information regarding their child's special healthcare needs with local EMS providers, so that this information can be shared with dispatch.
 - j. Adjourn: Meeting adjourned at 12:00pm by Dr. Kim.
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8. Physician Advisory Committee (Andrews)

- a. Roll call of PAC: Steve Andrews, Mark Schultz, Chuck Cady, Michael Clark, Riccardo Colella, Christopher Eberlein (remote), Sean Marquis, Steven Zils, Suzanne Martens.
- b. Motion by Chuck Cady, second by Mark Schultz to approve the meeting minutes of the October 17, 2017 meeting. Motion carried unanimously.**
- c. Motion by Chuck Cady, second by Mark Schultz to approve the minutes of the July 25, 2017 meeting. Motion carried unanimously.**

Report from State Medical Director (Dr. Martens)

i. Review Hours and Activity of Dr. Martens Since October Meeting

Hours: September: 52.25, October: 88.5, November: 42.25 = 61hrs/mo avg

In the midst of compiling 2017 into categories: general, emails, travel time, phone/texts, meetings. Approximately 1/3 of time is for meetings, 1/3 for general business, 20% travel, less than 10% for phone/text communications. Less protocol review than expected. I have been in contact with new medical directors.

No new national meetings. Information forwarded from NASEMSO to PAC – National Standard Curriculum update; Narcan use article WI EMS Plan public hearing with EMS Section in Wausau on 11/30/17.

Locally I was able to attend and observe 2 large scale MCI drills. Plymouth held a county-wide bus crash drill. Valders held an active shooter drill at the high school.

****Note that the WiTrac and EMTrac utilization was much better in Manitowoc Co, but required dedicated staff.**

The Plymouth drill confirmed significant weaknesses in the MABAS cards. And the use of plastic people was different.

When you know all the plastic people are dead no one actually triages them. I recommend some of them not be dead.

Theater students are better patients than teachers.

Discuss the suggestion that every ambulance should transport 2 patients. PAC agreed this is not always possible if a Red tagged pt requires care. Recognize that Green pts are likely going to a different facility.

- d. Review Communications and Inquiries Received by Medical Director
CCP definitions with regard to interfacility versus 911 scope of practice.

1 brand new Medical Director for paramedic agency

Legacy medications – discussed later

SIPQuik cervical splint: a vacuum splint for the neck, supposedly fits any size, inexpensive. Stabilize In Place Quickly. Limited information on EMS use. Discussion that c-collars do not appear to be FDA approved, but being supplied by EMS equipment companies. We don't endorse particular products, but SIPQuik may be used for cervical immobilization.

EMS agency in need of a new Medical Director – suggestions to switch in a limited coverage area = ask at RTAC, ask HCC Medical Advisor, ask highest level receiving facility; if no luck, let Office know

- e. Discuss EMS Quality & Performance Improvement and provide recommendation and possible vote

PI points for EMS per WI Trauma System: EMS Quality Indicators

i. EMS scene time > 20 minutes

ii. Completed pre-hospital patient record provided or available to the trauma care facility within 48 hours.

iii. A Glasgow Coma Scale (GCS) < or equal to 8 and no definitive (protected) airway for EMS and hospitals

iv. The time at the referring trauma care facility exceeds 3 hours exclusive of the transport guidelines.

I believe the last point is listed in error.

Not sure the scene time is impactful. Discussion that this is useful to flag the call for review to make sure it is moving along promptly. 48 hour mark: The WARDS requirement is to have report uploaded within 7 days. Many agencies have policy that reports must be done in 24 hours. Barriers identified include that the tertiary facility does not have access to the report in WARDS as they are not identified as the destination. Discussion on pt tracking with unique pt ID number, would require routine use.

Airway management: Agree on management, does not imply need for intubation. Documentation of adequate oxygenation and ventilation.

ED length of stay may reflect a system deficit if there is a delay in providing appropriate transport services.

Discuss c-spine protection in suicidal hanging situation [strangulation more than SCI]

Evaluate for trauma versus suffocation mechanism for indication of c-collar.

- f. v. Discuss EMS Scope, Best Practices, Skills, Medications and Equipment and provide recommendation and possible vote
- g. SIPQuik cervical splint already discussed
- h. vi. Discuss Updates to EMS Protocols and provide recommendation and possible vote
- i. Legacy medications: medications that have previously been approved but now seem to be in the Critical Care scope. Trying to achieve consistency and fairness in maintaining system coverage. Discussion on local needs. Discussion on the responsibility of the hospital to provide appropriate transfer staff. Recognition that this discussion has occurred previously, more than once. Considerations of time to advance to Critical Care scope, cannot do this instantly. Previous practice should be allowed to continue if effective locally and safe. Considerations of distance; longer transports of complex pts require more support. Discussion of 2 year phase-in period to require Critical Care in areas performing complex transfers. Dr. Martens recommendation is to allow agencies who currently have non "curriculum" medications to continue to do so, some of these definitions have been approved but not yet enacted, and that this committee was to be receiving WARDS data on interfacility transfers but this is not happening. There is a Critical Care work group being developed to evaluate this use. To be discussed further tomorrow, on the agenda. Previously approved PAC recommendation discussed and endorsed "Legacy Medications in Paramedic Operational plans to be allowed to continue, with requirement to have training and testing at least every 2 years on those medications. If State EMS office has concerns regarding medications, defer to State Medical Director opinion" (June 2017)

Motion by Cady to allow current agencies with Medical Director approved medications to be approved. No second. Motion dropped.

Nothing beyond pending PAC protocols with need to update format for website. Will bring more once format is settled.

- j. Discuss separate website for sample protocols
 - Develop NAEMSP-WI Chapter "library". Acknowledged that involved EMS Medical Directors freely share protocols. Considerations for de-identified documents or abstracts of reference articles. PAC in support.
 - Discuss State Medical Director issues needing advice regarding particular service equipment or protocols and provide advice
 - No further [14:16]
- k. Communication with State EMS Office (James Newlun)
 - Discuss status of WARDS Elite QA and expected timeline
 - Identified problems with current data dictionary. Image Trend rep is investigating. Consideration of a Medical Director training session.
 - Discuss continuing education requirements for renewal and clarify medical director responsibility for verifying and signing off on continuing education requirements
- l. Medical Director must ensure the training is true and accurate. What is the Med Director actually responsible for? If training not given

by the Med Dir or their designee? There are many more on-line programs and who is controlling the content? Schultz commented that we went from the Medical Director being very involved to not at all involved back to responsible. The document does not allow the Medical Director to sign only parts of the topics. There will be some unknowns for this renewal cycle.

Document on website lists "Pre-approved in-house training approved by the EMS office and [supposed to be "or"] EMS service medical director. Document is in the 2018 Renewal section, not Forms.

Concern that this will come down to the deadline and there will be many renewals to process.

Question of non-affiliated EMT taking flexible refresher. EMS office will accept CAPCE approved education. EMS Office will accept non-signed forms.

- m. Discuss LifeVac as suction (again) and may make motion.

<https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm?ID=K940934>

[14:42] Question on being FDA approved. Dr. Andrews did find that it was accepted as an "equivalent" device. Clinically, it does not meet ambulance minimum suction equipment, can be used under scope of practice..

Discuss Stroke Publication best practices <https://www.dhs.wisconsin.gov/publications/p01158.pdf> and may make motion.

- n. EMS Section confirmed that this document was previously processed and accepted. No new action.

Discuss Cover Letter for Pre-Arrival Instructions (Dr. Marquis) and motion to adopt

This was previously reviewed, some cautionary points added that this information is not equivalent to having an official EMD program.

The emphasis of these actions are focused on potential life-saving interventions. They are not comprehensive.

Motion by Cady, Second Zils to discuss letter for pre-arrival instructions (Dr. Marquis) and adopt. Approved unanimously.

- o. Discuss status of Pre-Arrival Instructions and make motion if necessary

The document needs to be formulated and it will take time. Approached Brooke Lerner, who did not have a person to do this at this time. Meier will try to facilitate.

- p. Discuss progress on CARES Registry (Drs. Zils & Andrews, James Newlun) and make motion if necessary

Nothing new

- q. Discuss WI Controlled Substance document (Dr. Zils) and motion to approve

The DEA bill passed, but the details are being evaluated. WI still needs to recognize EMS as midlevel provider.

Until new DEA regulations developed, no action can be taken. Until DEA has regulation, will remove from PAC agenda.

- r. Discuss Undesignated Trauma Center transport and make motion on recommendation (Dr. Clark)

See Dr. Clark's document. Extensive discussion.

Cady: add "ideally" in the destination decision.

Discussion on the impact on the local system with an Unclassified facility. Concern to use closest facility for a patient without an airway or is otherwise unstable; can provide treatment and stabilization.

This document augments the WI Trauma Triage Guidelines, does not replace it.

Minor injuries not otherwise defined on the Triage Guidelines may go to Level 4 or other non-trauma facility. "or hospital capable of providing care."

When is it appropriate to go to an Unclassified facility? To address an airway or other initial stabilization (unstable to drive the distance to the nearest TC) Or if they do not meet Step 5 Criteria (not a major trauma pt).

[Break 15:12 to 15:25]

Changed “all trauma patients” to those who meet Trauma Triage Guidelines.

Consider transport to...

bullet #2

Who goes to an Unclassified hospital? Airway or a situation the EMS provider cannot manage and the local hospital may be able to stabilize, and when other transport services (HEMS, ALS for airway) are not available

Motion by Andrews, Second Clark to accept Dr. Clark’s document on transport to undesignated trauma facilities. Approved unanimously.

- s. Discuss CQI guidelines and may motion to adopt as State CQI example guideline (Dr. Colella) MCEMS CQI document presented by Dr. Colella. Project updated about a year ago, looked at California core measurements and review of patient safety events. Measure domains: outcome, process (what did the provider do), structure (how the system works). Core measurements are mandatory (controlled substances, listed in 110, federal HIPAA) or system defined. Define compliance under each. System core measurements: Sudden Cardiac Arrest, STEMI, CVA, Trauma, Airway, Hospital Ambulance Diversion. 30 elements evaluated regularly. SCA example: 8 points measured in a clinical matrix by domains such as survival, witnessed event, CARES reporting, CPR quality, time to defib, peri-shock pause, first dose of Epi, pre-arrival coaching, correct destination. National guidelines standards.
- How to manage the patient safety side of evaluation? PDSA cycle approach. Define event schema: near miss, precursor event, serious safety event. Near miss events are the focus of airline safety; EMS is not quite there yet. Then define type of evaluation. Apply Just Culture approach to patient safety events. Duty to avoid causing the error, duty to follow a procedure and duty to produce an outcome. Outcomes as: support the provider, coach the provider, counsel the provider, discipline the provider (only for willful intent to harm or disregard for safety provisions).
- 6 “buckets” of safety events: procedural issue, environmental issue, patient protection, care management, ??, and criminal. May be in more than one category. Keep track of number of cases in each category to look for training opportunities.
- Have an adverse reporting form on the MCEMS website.
- They do use the protected info/document statement.
- Uses an adverse event reporting system with app on computer or phone, with Excel document. This identifies when and how to report. Get info from providers (primarily), hospital, patient, family. System not expensive, but does need a dedicated person. This has removed the “shame” from reporting. Removes the Medical Director as the “bad guy.” However, there are still some attitudes within the department to overcome.
- The California model uses regional standards, each department must fill in the data and submit. Establishes ownership on input. Noted that discussions do not de-identify providers and this has worked well. The process emphasizes improvement. Expect to generalize this program document and make available to post on EMS website.
- Discuss Scope of Practice in general (Dr. Clark)
- t. Discussion on the Role of individual EMS Medical Directors and PAC on future of scope changes, processes; national vs state processes
- [16:02] Systems Management brought forth questions on role of Medical Directors in scope changes. Recognize that the Medical Director needs some flexibility to advance their system, or outside forces will take over.
- u. Discuss upcoming changes to National Scope of Practice Recommendations (Narcotic antagonist EMR and above; Intranasal EMR and above; tourniquets and wound packing EMR and above) and motion to adopt. Previous motions by PAC and EMS Board have

anticipated these changes, except for the following motions that would need to be made to be consistent with the upcoming National Scope changes.

- **Motion: in scope of practice change “Naloxone (Narcan)” to “Narcotic Antagonist”**
- **Motion: Narcotic antagonist as required for EMR scope of practice (remove **)**
- **Motion: Tourniquet as required for EMR scope of practice (remove *)**
- **Motion: Wound Packing as required for EMR and above scope of practice (remove *)**

Motion Cady to accept all to maintain consistency with National Scope. Second Mancerra. Discussion that this will either add training hours, be part of transition, or replace part of current curriculum. Approved unanimously.

- v. Discuss Scope of Practice word change “Mark I Auto-Injector (or equivalent-for Self, Crew and Mass Casualty Incidents)” to “Atropine/Pralidoxime Auto-Injector (or equivalent-for Self, Crew and Mass Casualty Incidents)” and make motion to adopt (Dr. Clark)
- w. **Motion to use generic by Clark, second Cady. Noted that the brand name devices are in shortage, like many other medications. Discussion that this is consistent with other generic references as much as possible. Approved unanimously.**
- x. Discuss Minimum Equipment/Medication list Paramedic level care and motion to approve as State minimum (Dr. Andrews) Based on list from Connecticut. Items from Trans 309 highlighted. Also reviewed NAEMSP minimum medication list. Covers EMT, AEMT and Paramedic scopes. Add saline to bulb suction. Occlusive dressing is not on Trans 309. Broselow tape. Low temp thermometers. Portable sharps container.
- Noted that pulse oximetry is in the National Guidelines, and this is optional at all levels in WI. Discussion on scope and training versus equipment requirements. Recommend that pulse oximetry be required at the Paramedic level.
- Define amount of Narcan to be carried.
- Starting from the top:
- Consider other O2 masks capable of high-flow (Oxymasks). Does this also apply to pediatrics?
- NPAs need to be defined. Trans 309 requires 6 between the size range to cover peds-adults.
- Question of the need for pediatric ET tubes if the agency does not perform pediatric intubation.
- Ask Peds EM about the need to stock peds defib pads. Has been discussed, unsure of requirement. Believe the intent is that adult pads may be used in emergency, pediatric pads should be stocked. However this is NOT on Trans 309.
- Difference between child-sized spine board and short extrication board? Line 53.
- Pediatric stethoscope? = remove
- Add occlusive dressing or equivalent
- Can eliminate pillows as required
- Rename Smart triage pack to generic MCI tag pack
- Discussed that saline drops are not required. Can substitute with sterile saline otherwise available.
- Pediatric passenger restraint system: is there a minimum weight it covers? 20, 10 or 5lbs? Ask EMS-C
- Line 74 and 111 are same
- 1L bags x4 in particular? List as total of 4L. May not be able to always get 1L bags.
- 14g IV catheter is not required. Just “assorted sized catheters” and specify down to 24g. Probably minimum 2 of each.
- **continue discussion at next meeting; ask EMS-C
- y. Discuss need for Secretary position on PAC and motion to add Secretary position to elected officers starting in 2018
- Add Secretary position to come into compliance with board and council structures. Historically the previous PAC chair has transitioned to the State Medical Director position and has assumed the role of note-taker. The Secretary would also take notes for additional details.

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- z. Elections: Chair and Vice-Chair PAC to start 2018. Also PAC Secretary position to start 2018, if approved as position.
 - aa. Elections overdue, were to be at the first meeting of every year.
 - bb. Andrews nominates himself as chair. Schultz nominates himself as vice-chair. No nominees for Secretary. Unanimous approval.
 - cc. Discuss items for next PAC meeting. Next PAC meeting February 6, 2018
Adjourn 17:00

Prepared by: Sandy Ryce, Erica Kane, and Suzanne Martens on 2/1/2018.

These minutes are in draft form. They will be presented for approval by the governmental body on: 2/6/2018