
NEW YORK STATE EMERGENCY MEDICAL ADVISORY
COMMITTEE

(SEMAC)

September 10, 2008

1:30 p.m.

Best Western Sovereign Hotel

Albany, New York

APPEARANCES:

Dr. Timothy Haydock

Dr. Mark Henry

Dr. William E. Huffner

Dr. Lewis Marshall

Dr. Daniel Olsson

Dr. Craig Van Roekens

Dr. Bradley Kaufman

Dr. Joseph Takats

Dr. Terry Fairbanks

Dr. John Broderick

Sharon Chiumento

Michael Mastrianni

Dr. McEvoy

John Hasset

Robert Delagi

Mark Zeek

1 DR. HENRY: First item then would be review of the
2 minutes from the last meeting. And we can also take a
3 motion to accept the minutes from the meeting before
4 with the corrections noted in the minutes before you.

5 DR. BRODERICK: So moved.

6 DR. HENRY: Do you have anything to add, Sharon?

7 MS. CHIUMENTO: I do have a few corrections.

8 Page 20, normal thermia should be normothermia,
9 one word.

10 Line 19 on page 40, that nurse subordinator, I think
11 it's probably nurse practitioner.

12 Page 83, line 13, Twopam, should be the number 2
13 Pam, not spelled out t-w-o.

14 On page 92, P-CEPS should be PSAPs, p-s-a-p-s.

15 Page 88, line 23, we have Miss Chiumento and Miss
16 O'Connor. It should be Ms. I believe that's it.

17 DR. HENRY: Does anyone else have anything? So,
18 then the motion with the items for the previous month --
19 previous meeting's minutes with those corrections and
20 the ones that Sharon has added to this.

21 All in favor?

22 (Hands raised.) Opposed. Okay, accepted. Thank
23 you. Since the last meeting I had been contacted by
24 cardiac advisory committee about a conference call

1 that's coming up. So, while we move ahead with our own
2 regional plans they are still working on the state effort on
3 this. I will let you know after that call what transpired.

4 I have no other correspondence. I would like to
5 move forward with the standing committee reports and
6 start with medical standards.

7 Let me just say that our last meeting we didn't
8 have a formal quorum, though we brought up several
9 motions from the one before. Those were in your minutes
10 before you, the detail on that. And then we have some
11 action from today's meeting, too, so I will let Dr. Marshall
12 move us for that.

13 Let me go myself out of order. We had a roll call of
14 the members at the table, but I asked and I appreciate we
15 have coming members to the table representing regions
16 who weren't introduced in the roll call because they are
17 not yet vetted, but we want their input and we want to
18 acknowledge you are here.

19 So, if we can go around the room and if you weren't
20 called at the roll call would you just please identify
21 yourself, the region you are from, so we have you on the
22 record and we all know you as you participate in the
23 discussions.

24 DR. GOODMAN: Carl Goodman, Suffolk County.

1 DR. HENRY: Thank you, Carl.

2 DR. COOLEY: Craig Cooley, Western REMAC.

3 DR. HENRY: Thank you, Craig.

4 DR. DAVIDOFF: Jack Davidoff, Finger Lakes
5 Region.

6 DR. HENRY: Thank you. Dr. Marshall.

7 DR. MARSHALL: Thank you. Medical standards
8 met this morning and we have many action items to bring
9 forward. I will bring them forward. They may seem a
10 little out of order than we discussed this morning, but I
11 would like to do the less controversial ones first.

12 And I will also mention the -- bring forward again
13 the motions from the last meeting so that they can be
14 acted on.

15 The first action item was withdrawal of a motion,
16 and there was a proposed motion from the previous
17 meeting in which the Central New York REMAC had put
18 forth a study using Propofol in the pre-hospital setting.
19 That motion has been withdrawn by the region.

20 There was one other motion that was reconsidered
21 by medical standards which I will mention a little later.

22 Next action item was presentation of Nassau
23 protocol regarding cyanide toxicity. Nassau REMAC
24 brought forth suspected cyanide toxicity protocol which

1 is to be used, from my understanding, in a mass event.
2 The antidote kits will be maintained at the Nassau
3 Medical Control Center and available in an emergency. I
4 understand they will not be on the ambulances, correct
5 me if I am wrong about that.

6 The use of IV hydroxocobalamin and sodium
7 thiosulphate is a medical control option. The rest is BLS
8 procedures, oxygen and advanced airway if needed, IV,
9 EKG, vital signs. That comes forwarded as a second
10 motion.

11 DR. HENRY: Any discussion? All in favor.

12 (Hands raised) Opposed. Passes.

13 DR. MARSHALL: The next action item is New York
14 City protocols. New York City REMAC presented a series
15 of protocols which included changes to general operating
16 procedures, as well as specific protocols.

17 And those protocols -- general operating procedure
18 changes including transportation regarding patients who
19 are having ST elevation MI, patients who are requesting
20 to go to not the closest hospital but a hospital of the
21 patient's choice, airway management, shock, definition of
22 shock, prehospital sedation in New York, and they moved
23 all their -- instead of having each protocol where you have
24 prehospital sedation, they moved it to one general

1 operating procedure. Took it out of the individual
2 protocols.

3 Elimination of endotracheal drug administration,
4 consistent with the American Heart Standards, use of
5 intranasal drugs, controlled substances for pain
6 management, and some pediatric drug dosage and fluid
7 administration. Again, eliminating endotracheal route of
8 administration.

9 There were some other specific clinical protocols
10 which included their weapons of mass destruction nerve
11 agent exposure protocol, and was just changed to be
12 consistent with the new formulation of the auto injectors
13 that are coming out.

14 Non-traumatic chest pain, asthma, pediatric
15 asthma, poisoning and drug overdose, eliminating
16 activated charcoal given in a pre-hospital setting, head
17 and spine injury protocols to be consistent with the
18 protocols issued by the state recently, and cold related
19 emergencies.

20 Recommendations by the committee were to
21 accept the New York City protocol with the following
22 exceptions: To remove protocol 502, obstructive airway
23 changes, which describe the procedure where if
24 somebody had an obstructed airway, foreign body

1 obstructed airway, endotracheal tube would be pushed all
2 the way into the right main stem bronchus.

3 Theory being that you would push the foreign body
4 into the right main stem. You then pull the endotracheal
5 tube back and above the carina and ventilate, the theory
6 being that you would ventilate at least one lung. That
7 protocol was removed.

8 We recommended checking blood glucose levels
9 for seizure patients and those with altered mental status,
10 and removing the word "Broselow tape" wording and
11 putting in "length based measuring device."

12 The reason for that being is we don't want to list
13 any protocol in specific proprietary name but we just
14 want the item. That was approved and that group of
15 protocols comes forward as a seconded motion.

16 Are there any questions or Dr. Kaufman is here as
17 well as myself.

18 DR. HENRY: Hearing none, all in favor of the
19 changes please raise your hands.

20 (Hands raised.) Opposed? Abstentions? It passes.

21 DR. MARSHALL: Thank you. I'm going to
22 re-present the protocols that were approved at the
23 previous medical standards. Western region protocols
24 were approved at the previous -- not today's meeting but

1 the previous meeting with the following changes: To
2 eliminate the use of atropine for high level block and
3 going directly to transcutaneous basing; remove active
4 cooling and post cardiac arrest protocols.

5 That was an issue that a lot of hospitals and
6 pre-hospital regions are looking into the use of controlled
7 hypothermia in post arrest patients, but that was
8 removed.

9 Critical care to use CPAP, and that the critical care
10 EMTs will be taught using the currently approved
11 paramedic curriculum section dealing with CPAP. So, if
12 any region -- there was a lot of discussion on that at the
13 prior meeting so that if any region is going to bring this
14 CPAP to the TC level they should use the paramedic
15 curriculum on CPAP.

16 DR. HENRY: Any questions on the western region's
17 protocols? Comments?

18 All in favor, please raise your hands.

19 (Hands raised.) Opposed? Abstentions, pass.

20 DR. MARSHALL: Hudson Valley, I think we already
21 talked about. Hudson Valley also had TCMTCC training
22 using the CPAP so their protocols were approved -- their
23 CP protocols were approved using the paramedic CPAP
24 training curriculum. That came forward also.

1 Any questions on Hudson Valley? All those in favor
2 of approving Hudson Valley changes?

3 (Hands raised.) Opposed? Abstained? Motion
4 carries unanimously. We did have some discussion on the
5 New York

6 City Fire Department's rescue medic protocols that
7 were presented at the previous medical standards
8 committee but we are waiting on the curriculum to be
9 supplied by the fire department.

10 Dr. Gonzales is going to supply us with that. Do we
11 have any updates?

12 DR. KAUFMAN: I believe he said it was submitted.
13 It might have been -- I know he's been deployed to the
14 Gulf Coast for the past two weeks but I spoke to him right
15 before that and he said that was complete.

16 DR. MARSHALL: I don't think the department had
17 received them yet, so, Andrew said we didn't receive
18 them yet.

19 Other motions that were approved at the prior
20 medical standards meeting, there was a lot of discussion
21 on the use of waveform capnography, that the initial
22 meeting the motion was proposed is that waveform
23 capnography would be required for all breathing awake,
24 breathing alive, intubated -- patients who were being

1 intubated.

2 That was then changed to not only intubated but
3 anybody that was alive using an advanced airway device.
4 That came forward at the last meeting, but was not
5 approved at SEMAC.

6 So there was more discussion this morning on that.
7 And a new motion, which will be shown up on the screen,
8 is to include waveform capnography as a requirement for
9 all patients with advanced--no, it was changed.

10 Continuous waveform capnography will be used for
11 all patients who have endotracheal intubation initially and
12 continuously thereafter.

13 DR. HENRY: That's a motion from the committee.
14 Any discussion?

15 Yes, Dr. Takats.

16 DR. TAKATS: As of a date?

17 DR. HENRY: It's not a date. This has to do with
18 before it was pediatric, all pediatric, there was adults
19 who are not in arrest. This has to do with the type of
20 patient that this would apply to. This does not deal with
21 a date.

22 Any other questions or discussion? All in favor,
23 please raise your hands.

24 (Hands raised.) Opposed? Abstentions. Okay,

1 carries.

2 DR. MARSHALL: There was some discussion. The
3 original motion on the use of waveform capnography was
4 that it be implemented January 1, 2009. And working
5 toward that date there is going to be a SEMAC advisory
6 that is being evaluated and revised, we revised it this
7 morning, which would list the motion -- basically state
8 that all patients will require -- all patients who are
9 intubated with endotracheal intubating will require
10 waveform capnography initially and thereafter.

11 It lists primary and secondary means of
12 confirmation. There's a lot of discussion on whether or
13 not to mean colormetric devices in the advisory, and it
14 was felt that the committee should keep it in there
15 because if your device fails then you would need some
16 other mechanism of determining where an endotracheal
17 tube is.

18 In addition to that, there was a lot of discussion
19 and the medical standards committee, as a group,
20 determined that or decided that waveform capnography in
21 these situations is the current standard of care in New
22 York State and it should begin January 1, 2009.

23 The committee felt that regions have had notice
24 since we have been discussing this and has been

1 webcast in the past, and the committee felt
2 overwhelmingly that we should continue with the date of
3 January 1, 2009.

4 There was some discussion, and Mr. Wronski may
5 speak to this, in terms of other regions who may have
6 difficulty, and some discussions at the state level in
7 terms of what the implementation -- of delaying the
8 implementation date past January 1, 2009.

9 MR. WRONSKI: Setting a date for implementation
10 for any advisory recommendations or protocol
11 recommendations that may be new and may cost money,
12 they always take into account how it affects the EMS
13 system in their ability to find equipment and put it in
14 place and have training done.

15 The use of waveform capnography is not complex.
16 It does cost money. We have heard -- the Department has
17 heard from some services and agencies that this would
18 be a problem, and there was discussion about whether or
19 not a regional waiver can be done.

20 So, I certainly want to put on the table and get
21 advice from the SEMAC, and then tomorrow from the
22 council, because the Commissioner has to approve the
23 advisory, as to what we ultimately should do.

24 I think that the advisory should have a clear date.

1 That could be January 1, '09. Potentially it could be a
2 couple of months later but I think there should be a date.

3 Whether or not there is an ability for a region to at
4 least temporarily waive it I think should be discussed.
5 And then what's the criteria? If an agency says, listen,
6 we really cannot do this in the next couple of months,
7 give us a six-month waiver, we will work at it, we will find
8 a grant and do this.

9 In the interim what do we say they do? Do they
10 have 100 percent QI? Does the REMAC discuss with their
11 medical director about what they will do to confirm tube
12 placement in the interim?

13 What kind of things do we put in place if we do
14 grant a waiver? So, those are things I think I would like
15 to hear both from this group and from the council.

16 I am not closing the door on a different date, but I
17 do believe that we need a date to push this along. I think
18 it's pretty clear from everybody at SEMAC that this is the
19 standard of care and it's critical for patients. So, I would
20 just like to hear from some of you with your thoughts on
21 this.

22 MR. ZEEK: I wonder if it wouldn't be advisable to
23 request the regional councils and the REMACs to survey
24 their services to see what the compliance might be, to

1 see how big a problem we might have between now and
2 the December meeting.

3 DR. TAKATS: I have had six agencies in our region
4 state that they could not do it by the effective date, six
5 out of 130. Those are the ones that wrote letters.

6 MR. WRONSKI: I think, unless somebody tells me
7 different, we are not talking a large percentage of
8 services, but there will be some affected.

9 DR. DAVIDOFF: I think as you get into some of the
10 other regions where we are dealing with smaller
11 agencies, such as Finger Lakes and Dr. Takats' areas, it
12 is a larger percentage than some of the larger regions.

13 We are probably going to look at the same number,
14 maybe six or seven of our agencies. So, that's about a
15 fourth or fifth of our agencies. Not a large number of
16 patients, but still a fair number of patients would be
17 involved.

18 I think with time we might be able to get them to
19 be able to come up with the money. We will probably see
20 a reduction in the cost of equipment over the next few
21 years as well.

22 So, there may be some assistance to these
23 agencies if we could delay the immediate
24 implementation.

1 DR. BRODERICK: From a small region, Mountain
2 Lakes, ourselves, but we seem to have, I believe, nearly
3 100 percent compliance with this, knowing it was coming
4 for quite sometime.

5 I would also add that do we have the proven
6 benefit of pre-hospital endotracheal intubation. With the
7 literature being as it is, I am not convinced 100 percent
8 we do. We do have a lot of bag valve mask studies
9 recently, understanding that those studies are always --
10 seem to be in an urban area, so your transport time
11 certainly is a good point of discussion.

12 However, I can think on the flip side, though, we
13 have pretty good evidence that would suggest that
14 misplacement of that tube, which really capnography is
15 looking at a surrogate marker of making sure oxygenation
16 to the brain continues, can be devastating.

17 If -- and I would say if and I wouldn't necessarily
18 favor a waiver. I would say that those areas would have
19 to have almost a hundred percent QAQI right now, how
20 are they confirming their intubations, because we know
21 capnography, the point of it is to confirm the tube is in
22 the correct place 100 percent of the time.

23 How are they retrospectively going and doing that
24 right now? I am not convinced there are any regions,

1 certainly not ours, is going to have that robust QA/QI of
2 making sure that that tube is in the right spot.

3 DR. VAN ROEKENS: I guess I would just state that
4 if there is a waiver form then how do we allow -- how do
5 we explain in an esophageal intubation that could occur
6 during that time frame. I am not, for one, really willing to
7 be able to explain that, so, I would prefer to stick to
8 January 1, 2009.

9 DR. MARSHALL: I think that's one of the reasons
10 why the medical standards committee was so strong in
11 their opinion that this should begin January 1, 2009.
12 There should be no delay.

13 DR. DAILEY: I think our region first implemented
14 mandatory waveform capnography for pediatric
15 intubations about five years ago, six, after the first papers
16 came out and while we were reviewing things like
17 Gauchet studies out of LA.

18 There is no question that this is the standard of
19 care across the country. The thing that I would be most
20 concerned with for an agency that would seek a waiver
21 would be what sort of medical legal liability are they
22 placing themselves in?

23 This is very clearly the standard of care. You have
24 over two years of testimony in this body that it is the

1 standard of care, and if you are choosing to intubate
2 without this tool in place what risks are you placing
3 yourself, A, your agency, B, your paramedics at, and what
4 liabilities is the medical director facing?

5 I think our position at the state needs to be protect
6 the citizens of the State of New York and keep the
7 deadline as the 1st of January.

8 DR. HASSETT: Just on the issue, a couple of items.
9 First of all, when we passed the policy or protocol on how
10 we were going to handle waveform capnography, that
11 was in December last year.

12 In nine months, it took us nine months to come up
13 with a piece of paper that tells agencies out there to go
14 out and buy this equipment. Took us nine months to get a
15 piece of paper out there and we are going to go and tell
16 agencies that in three months they have to have a few
17 thousand dollars available in equipment regardless of
18 whether they can afford to get it right now or not, or
19 regardless of the fact that they are in the middle of their
20 budget cycle.

21 I think it's ludicrous to believe that we can have a
22 piece of paper take nine months to come out, but we
23 expect everybody to go out and spend thousands of
24 dollars in less than three months.

1 And, oh, by the way, you think it might be arbitrary
2 and capricious to believe that we have made the decision
3 to pick a date of January 1st a year ago almost, and we
4 decided now that the date of January 1st will stay even
5 though we are just coming out now and making it a firm
6 decision and putting out a piece of paper that tells them
7 they have to do that, so that the municipalities can go
8 ahead and budget based on this final piece of paper
9 which they will eventually get. I think we need to really
10 think about that.

11 MR. WEDGE: Has anybody thought about the
12 education component, that we are going to have to start
13 putting in classes and are we going to be changing the
14 intubation for a protocol and practical exam sheets?
15 That's something else I think you have to take into
16 consideration with this whole process.

17 DR. HENRY: I know Deb Fults has been thinking
18 about it because at last council meeting she raised the
19 query about why were adults in arrest excluded. It didn't
20 make a lot of sense. So, education has been thinking
21 about it based on their input.

22 Do you want any further discussion?

23 MR. WRONSKI: No. I appreciate all of that. I
24 wanted to hear from the group, and I certainly want to

1 hear from the council tomorrow as well. Any advisory
2 does have to be signed off by the Commissioner.

3 So, Commissioner should hear your voice, and what
4 you think about these things. I think it's clear that
5 capnography is the standard of care and that we want to
6 implement it.

7 The only open question is how to implement. Is it
8 January 1st? Is there some modification to that? But
9 hearing from you is helpful.

10 DR. COOPER: I think that it's very clear, as others
11 have stated, that this is the standard of care. In fact, it's
12 been the standard of care for sometime.

13 The liability issues, I think, in some ways, are moot
14 because it is the standard of care, and were the issue to
15 be raised as to why end title capnography was not
16 currently being given, that the Heart Association has
17 endorsed it, I think services might have a difficult time
18 supporting that position.

19 So, I think all encouragement that this body and
20 the Commissioner can give our pre-hospital advanced life
21 support services in this regard is really vital.

22 DR. MARSHALL: Continuing on? Yes.

23 DR. HUFFNER: I would suggest, Dr. Cooper, that
24 that encouragement might also include the ability for an

1 individual REMAC to evaluate an individual service's
2 position in terms of finances, in terms of its ability to
3 comply with this and to give them a certain time frame for
4 compliance.

5 I am not suggesting that we shouldn't enact this
6 standard of care as a requirement for the state, but I
7 would suggest that the individual REMACs be allowed to
8 evaluate the individual services.

9 The alternative will be that in some areas of the
10 state with some services they will choose not to perform
11 endotracheal intubation, which I am not sure that's what
12 we want to do.

13 DR. HENRY: So, I would--

14 DR. COOPER: I just wanted to add that
15 enforcement of protocol does not take place in a vacuum.
16 I think that the Department, in its infinite wisdom, will of
17 course take into account individual circumstances
18 involving individual agencies, if there is a compelling
19 need to do so.

20 But I think that for us to establish a waiver process
21 that would, if you will, encourage opting out of a medical
22 standard of care, would be a mistake.

23 DR. MARSHALL: In the advisory that was just
24 handed out, on the right-hand side there are two

1 comments. Those will be deleted.

2 The section under "purpose" will be changed to
3 include "all patients" and "advanced airway device"
4 changed to "endotracheal intubation" or "endotracheal
5 tube."

6 Under the confirmation procedures, the words
7 "initial" and "secondary" will come out, and that will be
8 one section just called "confirmation". And then the
9 second section will be "definitive and continuous
10 confirmation". And then the rest will stay the same.

11 There's still going to be a QAQI process attached.
12 Some regions will need to do QAQI and then report this up
13 to the SEMAC.

14 Those are the changes that are going to go on the
15 document that you have in front of you.

16 DR. HENRY: This is what's proposed to go out as
17 our advisory if the Commissioner signs off.

18 DR. FAIRBANKS: I just had one other comment in
19 terms of the time and the fact that I think we all can
20 agree that there may be some agencies out there that
21 can't deal with this. That we are not saying that they
22 won't be able to manage as an agency. What we are
23 saying is that we feel so strongly that this is a standard of
24 care they should not be doing endotracheal intubation

1 until such a time they can get this into their budget, and
2 by not having another extension I think it makes it a high
3 priority in agency budgets.

4 By that, I think our action is going to help agency
5 leaders that want to do the right thing. So, the worst
6 outcome from this, it's not such a bad outcome, is there
7 may be some agencies out there that are just using King
8 airways and alternative airways for an interim six month
9 period for airway management.

10 I think I would argue that's better and safer than
11 having agencies for a six-month period continuing to do
12 endotrach intubation without monitoring.

13 DR. HENRY: Accompanying this advisory I am
14 going to ask the Department, and I am asking for your
15 comments on this now, but I am going to ask Ed, through
16 the Department, to notify hospitals about this advisory
17 because they have a role directly in the QAQI process
18 where there's -- we have to develop and implement a
19 process to record physician verification of proper tube
20 placement on arrival at the emergency department.

21 And a good way to verify it would be CO2
22 monitoring in the emergency department. So, I would ask
23 the Department to issue a notice to that effect, this will
24 be effective in January and they can at that point transfer

1 in the hospital bed, when they come off pre-hospital
2 waveform capnography, they can ascertain with their own
3 equipment the fact that there is good waveforms and the
4 tube remains in place.

5 MR. WRONSKI: Dr. Henry had briefly discussed this
6 with me before. I indicated that we would be willing to
7 send a letter to hospitals asking for their cooperation to
8 work with prehospital system in what really amounts to a
9 QI process, as well as an evaluation process, if they
10 would be willing to do that.

11 We can't -- we certainly can't mandate it, but I
12 think if we send a letter out that -- from the Department,
13 that would help in many regions assure that hospitals
14 work with you on this.

15 DR. HUFFNER: If those EDs don't have waveform
16 capnography they will have to get it.

17 MR. WRONSKI: Those -- as by January 1st, that is
18 correct.

19 It would be -- certainly be expected that most
20 hospitals would have it. If they don't they might have the
21 ability maybe to evaluate tube placement.

22 I think a separate conversation that the Chair will
23 have with SEMAC at a later date possibly, or I don't know
24 if it's on your agenda for today to discuss the issue, the

1 law has changed and one of the roles of the SEMAC now
2 is, in fact, to review emergency department standards
3 and what happens in emergency departments and
4 potentially -- you can issue an advisory to hospitals with
5 the Commissioner's approval in areas of emergency
6 medicine.

7 So, technically, this is something you could
8 approach and advise hospitals that they should have the
9 ability for capnography. Different, though, than
10 pre-hospital. I have to underline that advisories that go
11 out in hospitals on this don't have as much strength
12 because the SEMAC and the State EMS Council really
13 develop and control pre-hospital medicine.

14 The law has given the SEMAC the authority to work
15 with the Department on changing regulations for
16 emergency departments and issue advisory guidelines to
17 hospitals, but the practice of hospital medicine is, in fact,
18 controlled by the hospital and the MDs who reside within
19 that hospital or work within the hospital.

20 So, it's a little different relationship, but it certainly
21 would set a tone if at some point SEMAC decided to send
22 an advisory like that out.

23 MR. BLUM: Dan Blum from Westchester region.
24 Just a point of clarification. There are a fair number of

1 patients who are transported from one Article 28 facility
2 to another, or even at times not even to an Article 28 but
3 to an alternate destination, where those patients are, in
4 fact, already intubated. These are interfacility transfers
5 or even perhaps transferred home on a vent, believe it or
6 not. Rarely for those.

7 So, does this standard also apply to the
8 interfacility transports even though the paramedic did not
9 intubate the patient in that case?

10 DR. HENRY: Yes.

11 MR. BLUM: Thank you.

12 DR. TAKATS: I mean this advisory defines the
13 requirement, but are we going to concomitantly set the
14 consequences for non-compliance to these people at the
15 end of the year? Because this came up under budget
16 discussion also and medical standards committee and I
17 think somewhere we have to let agencies know what the
18 consequences are going to be for non-compliance.

19 MR. WRONSKI: If I could comment, and I apologize
20 for jumping in.

21 There is really two areas that I see, maybe others
22 can think of others, for non-compliance with any of these
23 standards of the care. This can be applied -- one is a
24 REMAC, obviously, as I say, over ALS in its region. So,

1 locally or regionally you can take an action if you choose
2 to regarding an agency that's not compliant with your ALS
3 protocols or what you believe should be a standard of
4 care in your area or practice of ALS.

5 The Department, if it were to receive a complaint
6 about the care provided to a patient -- the worst case
7 scenario a patient is not intubated or is improperly
8 intubated according to a hospital that receives them, we
9 will find out capnography was not used, that would
10 certainly be one of the charges against the practitioner
11 and the agency in Department charges.

12 Of course, those are going to be rare. We get them
13 periodically and you don't see them too often. So, the
14 biggest issue is what does a REMAC do and what does a
15 regional council do with an agency that's not compliant
16 with standards of care in this area.

17 It varies in regions where we have seen a variety of
18 things that different regions have done with ALS services
19 particularly.

20 Dr. FAIRBANKS: If I could just make one important
21 point that I think was raised by the question from the
22 gentleman from Westchester.

23 It's important, I think, to say that this is not about
24 us as a group feeling that paramedics are not capable

1 and good at intubating. The worry is more, I think and
2 there's more emerging evidence, that it's dislodgement of
3 tubes that occurs after intubation.

4 So, it's not a question of skills from the paramedics
5 or the ALS provider. It's a question of dislodgement
6 occurs. That's the case when you get to the ED and the
7 tube wasn't where you put it and you say I am sure it was
8 in the endotrachea.

9 So, that's why it's so important on interfacility
10 transports, particularly with paralyzed patients, because
11 a SAP monitor will tell you eight to ten minutes after the
12 dislodged tube occurs, whereas end title CO2 tells you
13 immediately.

14 DR. HUFFNER: So, all Article 28 facilities receiving
15 patients in interfacility transfers have the capability to
16 also confirm waveform capnography?

17 MR. WRONSKI: I think all Article 28 facilities,
18 particularly yours, always has confirmed tube placement,
19 right? You receive a patient in an interfacility transport, I
20 think one of the things the receiving nurse does is check.

21 DR. HUFFNER: I'm sending the intubated patient to
22 a chronic care nursing home or something like that. I
23 wasn't worrying about coming into the hospital. I said
24 going out.

1 MR. WRONSKI: Listen, I think the reality is that we
2 can work with facilities and others who receive these
3 patients and ask for their assistance. Are we going to
4 mandate or is this going to happen in every facility all the
5 time? No, it's not going to. But I think this is another
6 way to try to build those bridges.

7 DR. HENRY: All right. That was a good discussion.

8 DR. MARSHALL: One more motion related to
9 waveform capnography. The Department of Health must
10 make public any agency name that is not providing
11 waveform capnography to meet the 1/1/09 deadline with
12 regards to requirement of waveform capnography. To
13 make public, just list on the website.

14 DR. HENRY: There was a motion from the body at
15 the last meeting.

16 DR. MARSHALL: At the May meeting, yeah.

17 DR. HENRY: Any discussion on that motion? All in
18 favor raise your hands.

19 (Hands raised.) Opposed? Abstentions, it passes.

20 DR. COOPER: Mr. Chairman, do the alterations on
21 the advisory guideline require confirmation by this body?

22 DR. HENRY: If you wish. I mean at the meeting
23 before there was general acknowledgement, but we can --
24 people can affirm that if they will. Are you proposing

1 that?

2 DR. COOPER: Yes, sir, I am.

3 DR. HENRY: Is there a second to affirm the
4 advisory with the changes made?

5 Second, okay. Any discussion?

6 MR. DELAGI: Just a couple of wordsmithing
7 changes based on the changes that you have already
8 made.

9 We struck the term "secondary confirmation" from
10 a heading but the term "secondary confirmation" remains
11 in several paragraphs in the advisory. I think we all
12 intuitively know what that means, but just for consistency
13 we may want to clean that up a little bit.

14 Under "background", on the sixth line, it makes
15 reference to "secondary confirmation", so for consistency
16 just strike it and have "primary and definitive".

17 DR. HENRY: We took this under advisement from
18 Dr. Dailey to make the change in this language and I
19 didn't know until lunch that he was an English teacher. I
20 understand that was intuitive for him that all that would
21 occur.

22 MR. DELAGI: We can fix that one real easy if that's
23 okay. Then if we are omitting -- under "confirmation
24 procedures" omit and in place put in "primary

1 confirmation", then under the "limitations" paragraph,
2 first line, it says "adjuncts for secondary confirmation". If
3 we simply make that "adjuncts for qualitative
4 confirmation".

5 And then on the fifth line, again, striking the word
6 "secondary" and adding "definitive" so that there is
7 consistency across the document with those terms.

8 DR. HENRY: We will make those editorial changes.
9 Any other notes? Hearing none, let me see the hands to
10 affirm this advisory then.

11 (Hands raised.) Opposed? Abstentions, passes.
12 Thank you.

13 DR. MARSHALL: I have two more proposed
14 motions to bring forth from this morning's meeting. The
15 first one is that there was some discussion about the
16 review of protocols about the monitoring of blood glucose
17 levels in the pre-hospital setting and the use of
18 glucometers.

19 As a result of that discussion the following motion
20 was proposed: Glucometry device is the standard of care
21 to determine blood glucose levels for all BLS and ALS
22 blood glucose monitoring.

23 After the discussion some -- the glucometer is used
24 in lieu of the glucose strips or dextrose strips that people

1 used to use, so we just want to make sure that people are
2 using a glucometer and not the dextrose sticks. That
3 comes forward as a seconded motion.

4 Questions?

5 MR. DELAGI: Again, just from a wordsmithing
6 perspective, the way it reads appears as though it's the
7 standard of care for all BLS agencies. I believe the intent
8 obviously is that for BLS agencies opting to do blood
9 glucose determination per the recently released state
10 policy.

11 I may just make a suggestion that we include
12 language like that to differentiate that for ALS it's
13 required since everybody is giving dextrose in the field,
14 but for BLS it's only those who are using glucometry per
15 the new protocol.

16 The way it's written now it makes it appear as the
17 blood glucometry is the standard of care for all BLS and
18 ALS agencies.

19 DR. MARSHALL: This really says for all BLS and
20 ALS blood glucose monitoring. Doesn't say anything
21 about the agencies.

22 So, if you have a BLS blood glucose program like
23 they do then you have to have it, but if you don't, you
24 know, make -- we could certainly make changes to the

1 wording. That's up to the committee.

2 DR. HENRY: Is the intent clear anyway?

3 DR. DAILEY: I think actually what, really, to clarify
4 what Mr. Delagi is suggesting we do with this, the reality
5 is there is no such thing as a basic life support dextrose
6 stick program. There is only BLS glucometry as here in
7 Albany, Dr. Oshkow in Albany.

8 So, I think what's important would be with this
9 advanced life support units in New York State that
10 administer glucose and serve in an advanced life support
11 capability should be at that level. It should be doing
12 glucose monitoring using a glucometer.

13 So, thank you for correcting my English, Mr. Delagi.

14 DR. HENRY: Do you want to put some language in
15 there or no? Is that acceptable?

16 MR. DELAGI: If it's intuitive it's acceptable I
17 suppose, I just was looking at it from the what if scenario.

18 MS. CHIUIMENTO: Can't we just do -- make it very
19 simple. Take out the "BLS" and "ALS" and put "any
20 agency doing glucose monitoring".

21 DR. HENRY: Or use the glucometer.

22 MR. DELAGI: That works.

23 DR. DAILEY: Actually what it does take out is our
24 assertion that there shouldn't just be random glucose

1 administrations in the field either, and that all advanced
2 life support units should be monitoring glucose in their
3 altered mental status patients.

4 DR. HENRY: That's a different issue, though. Two
5 separate things.

6 DR. OLSSON: If you are going to monitor then you
7 should use a glucometer, right, but...

8 DR. DAILEY: That's really what we are saying here.
9 The other thing, we should be looking at every protocol
10 that comes through, each region is insisting that its
11 providers be monitoring glucose.

12 DR. MARSHALL: The current motion now reads as
13 follows with the proposed changes: A glucometry device
14 is a standard of care to determine blood glucose levels
15 for all blood glucose monitoring.

16 Dr. Cooper.

17 DR. COOPER: To take a page from Dr. Dailey's
18 book, we might want to say either "glucometry is" or
19 "glucometry devices are" at the beginning. I don't care.

20 MR. ZEEK: Thank you. Dr. Funk made an issue of
21 that earlier.

22 DR. MARSHALL: Any other changes? Any other
23 comments? All those in favor raise your hands.

24 (Hands raised.) Opposed? Abstain? Motion

1 carries. One more motion that comes forward from this
2 morning had to do with the discussion of the ability to
3 defibrillate patients of all ages, and the realization that
4 there are or may be some transports that are occurring in
5 which patients are being transported who may need
6 defibrillation and there is no defibrillator available on the
7 transporting unit.

8 Now, also in instances where the service might be
9 providing care at the scene and need a defibrillator,
10 whether it's an AED or a manual defibrillator, and there is
11 none available.

12 So, the motion after some discussion comes
13 forward is: All ambulances treating or transporting
14 patients must have defibrillation capacity for all ages.
15 There was further discussion on the requirement for
16 pediatric pads for AEDs and our discussions at the last
17 few meetings where if a service is upgrading or getting
18 new AEDs that they should make sure that they are
19 pediatric capable.

20 DR. HENRY: Is there any discussion on the motion
21 before you?

22 Hearing none, all in favor please raise your hands.

23 (Hands raised.) Opposed. Abstention, one
24 abstention. That carries.

1 MR. LEWIS: Mr. Chairman, I know that bill passed
2 quickly, but I would like to make a couple of comments.

3 My name is Al Lewis. I am the representative on
4 SEMSCO from UNYAN. While everything I hear here today
5 means a lot as far as quality patient care, I have some
6 real concerns about costs.

7 It's imperative that we have glucometers and we
8 have waveform capnography and also AEDs on every
9 ambulance that has a patient on board.

10 I guess I have an initial question for Mr. Wronski if
11 maybe he could quantify for me how many ambulances
12 that are certified out there today that are not in
13 compliance.

14 What are we talking about here? Are we talking
15 about 200 ambulances? Are we talking 20 ambulances?
16 What are we talking about and what the costs are that
17 are associated.

18 Do you have any idea, sir?

19 MR. WRONSKI: No, I don't. There's about 5,600
20 ambulances in the state, not services but ambulances,
21 and there's another couple hundred ALS first response
22 vehicles.

23 Those are the ones that we directly oversee. I'm
24 not counting BLS first response that might carry an AED

1 in some areas. I do not know specifically. I do know for
2 a fact that over the last few years we have periodically
3 come across ambulances that do not carry an AED.

4 The service has them, but in some instances it may
5 not be an AED on the ambulance that's rolling. Now, is
6 this 20 ambulances in the State of New York out of
7 5,500? Is it 200? I would think it's somewhere in
8 between that.

9 I'm not looking at thousands of ambulances here.
10 I'm looking at I believe -- and I believe it's sporadic. I
11 think it has to do with potentially service that has more
12 than two or three ambulances and they may not have a
13 machine for each vehicle. That's what I believe.

14 There were up until recently -- I would have to
15 check with Lee when I see her -- there were actually
16 some volunteer companies that did not have AEDs. But,
17 to my knowledge, that's now gone for those are the single
18 ambulance services.

19 So, how many, I don't know. I just know it -- we
20 know it's out there and should be addressed, but it's not
21 thousands of vehicles. If I am wrong on that then I would
22 ask the services to advise us of such. That we have
23 much more, here's how many we have, in that regard.

24 As you know, in the equipment listing in the

1 regulation there's no requirement in regulation to carry
2 the AED. This is based on the protocol. AED is tied to a
3 protocol. It's not tied to regulatory language.

4 MR. LEWIS: I guess I can only speak for
5 proprietary companies and I can't speak for how many of
6 our ambulances that are out there may not have AEDs,
7 which creates a concern for all of us.

8 But, with that said, I guess I am, first of all, asking:
9 What's the time line we are talking about here for having
10 an AED on every ambulance operating out on the street?

11 Is there a time line of December 31st or what is it?
12 I didn't hear a time line.

13 MR. WRONSKI: We haven't set any time lines.
14 There was a statement that this should happen but there
15 was no date specific put on it.

16 Although once it's issued, obviously, if you are
17 silent on it it can tend to support that it should happen
18 now.

19 MR. LEWIS: I guess I would ask that we choose a
20 time line and I would ask that we choose a time like that
21 -- I agree, early defibrillation is absolutely essential, but if
22 you are going to -- you know, you think about the
23 economic climate we are living in right now.

24 Let me give you just a simple number that kind of

1 blows our minds trying to operate in this time and day.
2 My fuel costs last year were \$30,000. They are now
3 \$80,000, with no opportunity to recover those costs.

4 Insurance, employee costs and everything has
5 spiraled upward since September 11, 2001. We need to
6 be cautious that we are not pushing the balance of
7 driving ambulance companies out of business here.

8 Again, I will emphasize early defibrillation is
9 essential, but so is ambulance services in our
10 communities we serve.

11 So, I ask you to back off here just a little bit when
12 you are pushing unfunded, unfunded mandates. We do
13 everything we can to provide quality care. I believe
14 UNYAN companies do a hell of a job in the State of New
15 York, but don't push us financially where we can't
16 continue to do business in the state.

17 Who else is going to do it? The volunteers are on
18 their backs. Municipalities, some of them are in
19 receivership. What else is left?

20 Our companies are holding up most of New York
21 State when you think about it. We are the backbone of
22 the state when it comes to EMS because the volunteers
23 can't -- God bless the volunteers, they do a wonderful job,
24 but in our area alone you blow out four volunteer

1 ambulances, get one squad right now.

2 And that may be something that will change over
3 time, but that's the reality of it. The reality of us being
4 able to finance all these things you keep pushing at us is
5 going to break our backs over time.

6 We can't afford to pay our people what they are
7 worth now. You force these additional mandates on us
8 and I don't know what the end result is.

9 What I ask you to do, and I respect every one of
10 you at this table, and I'm not trying to take anything away
11 from what your intent is, but remember we have people to
12 pay, we have communities to protect every day of the
13 week, and if you continue to push mandates on us with
14 Medicare, Medicaid, third-party payers will not reimburse
15 us for all these things, and we collect 58 percent of every
16 dollar we bill, that is the state average of proprietary
17 companies alone. 58 percent is all we can collect
18 because of Medicare and Medicaid and other third-party
19 payers and HMOs will not pay us. Where the hell do you
20 break our backs with this type of stuff that you mandate
21 on us?

22 I would ask that when you implement something
23 like this and other things, that you set and find are
24 absolutely essential to the quality of life and saving

1 patients, you think about who's going to be left to provide
2 the care.

3 Thanks.

4 DR. VAN ROEKENS: Well said. Very well said.

5 Again, I guess what I would bring back to this
6 body, and the issue about the endotracheal intubation,
7 that does not necessarily have to have the high priced
8 waveform capnography if an agency has got an issue.

9 Ambu bag is a reasonable option. So is LMA. And I
10 think that that is actually a way that an agency could
11 deal with that. In our region, and I think across the state,
12 there are some areas that had an issue with that.

13 I think that's far better to do no harm than to do
14 harm and put a tube in the wrong place. Again, I think we
15 would be hard pressed to say that makes sense
16 irrespective of what the economic times are, recession or
17 otherwise.

18 The other issues, I agree. I think we can pull back
19 a little bit with some of the mandates in terms of that if
20 there is no funding for them, but I don't see that doing the
21 right thing for the patient with the airway issue, which we
22 have talked about for over three, four, five years here, is a
23 surprise to any agency.

24 I still think that care can be delivered and it can be

1 delivered safely to patients with an Ambu bag mask that
2 is a low cost, every agency has that. There are adjuncts
3 as well that can be done. So, I don't see that this is going
4 to break any agency.

5 MR. WRONSKI: If I could jump in here. One of two
6 things has occurred. Either the strong statements have
7 blown us off the web or we have too many internets.

8 So, I have to ask people who are on the internet to
9 shut it off at least temporarily because we have no signal
10 and we are unable to send it because of internet
11 interference because of the folks here on the laptops.

12 DR. DAILEY: I feel badly speaking without the
13 worldwide web as my audience as well, but it was my
14 motion so I feel as though I should speak, Mr. Lewis.

15 I certainly appreciate what the carriers from
16 UNYAN are doing, and the amount of patient load that
17 they are carrying within New York State and the amount
18 they contribute to EMS.

19 Among the things that we did at medical standards
20 was look around the table to see what the expectation of
21 the physicians at that table was of an ambulance that
22 arrived at either their site or in their hospital, and the
23 expectation in this day and age is that there be some
24 capability of defibrillation on an ambulance.

1 I think we have reached a point now where that is
2 the minimum standard for an ambulance for patient care.

3 I think we need to recognize Mr. Lewis' concerns,
4 certainly we will stand with you at attempting to increase
5 funding for ambulances. To get better funding for all
6 patients that are seeking emergency medical care is
7 important to all of us.

8 And we certainly don't want to see harm come to
9 our friends at UNYAN, but defibrillation is the minimum
10 standard expected when an ambulance arrives.

11 DR. HENRY: Dr. Fairbanks.

12 DR. FAIRBANKS: I also want to support the
13 concerns of UNYAN, but I think it's important that UNYAN
14 knows that we at SEMAC do take very seriously the
15 proprietary kind of business end there. So not -- my
16 biggest, largest agency that I'm medical director for is an
17 UNYAN agency.

18 But I think it's important to reinforce what Dr.
19 Dailey just said, and that's that this came out
20 inadvertently, almost all the people around the table were
21 shocked to hear that there was an ambulance in New
22 York State without defibrillation when it's required of the
23 schools.

24 It's the only thing that we do in EMS, the single

1 only thing we do in EMS that has proven to work.
2 Everything else that's been studied doesn't seem to make
3 any difference.

4 So, I think that -- I would -- I am shocked that an
5 agency, when we have known for 20 years this is the only
6 thing that works, would have an ambulance without
7 defibrillator capacity when our schools can do it and our
8 airplanes and casinos can do it.

9 So, I think that this was a reaction to surprise, and
10 our feeling is that if there is any agency that doesn't have
11 an AED that it should become a budget priority.

12 DR. DAILEY: Casinos are better funded basically.

13 DR. HENRY: Any other items? Any other action?

14 DR. MARSHALL: No other action items. Just for
15 your information, there were some projects that we
16 started working on over the summer, which I will just
17 mention.

18 One was how the state standard will be presented.
19 There was a lot of discussion about whether the protocol
20 format or the narrative so we will -- right now we will
21 continue working on that.

22 REMAC and REMSCO notification of changes and
23 new protocols, that system was put in place a couple of
24 meetings ago --last year actually -- for comments from

1 people within your region.

2 We were going to review the connection between
3 curriculum and protocols that permit treatment of
4 procedures that are not in the curriculum for the level of
5 provider that the procedures have been put in the
6 protocol for. So that there were some CC protocols that
7 were brought forward that had procedures being done by
8 the CC that were in the paramedic curriculum, so, that's
9 something that we are going to be looking at.

10 We have been asked -- medical standards was
11 asked to look at the safety issue and what -- to develop
12 recommendations on what can or should be done in the
13 back of a moving ambulance.

14 So, we have taken a list of all the procedures that
15 are in the current curriculum, BLS and ALS curriculum in
16 New York State, and put those into a grid with
17 recommendations for whether or not the provider can do
18 a procedure with caution in the back of a moving vehicle
19 unbelted -- I'm talking about an unbelted provider --
20 versus skills and procedures that should never be done in
21 a moving ambulance, whether you are belted or not.

22 So, that will be sent around and we will have some
23 more discussion for the next meeting for that.

24 We are also working on the state formulary. A lot

1 of regions have added medications to their protocols so
2 we are waiting for a few regions to submit their
3 formularies so we will put it in a grid and we will develop
4 a comprehensive list for a state formulary as it exists
5 today. I think the last time it was done was many moons
6 ago.

7 That was our report.

8 DR. HENRY: Thanks. Questions? Let's move to
9 the QI committee report, Mr. Delagi or Dr. Kaufman,
10 please.

11 MR. DELAGI: Thanks, Dr. Henry. Our committee
12 met this morning. Staff has the attendance sheet. We
13 don't have any seconded motions that will come up either
14 today or tomorrow.

15 Dr. Kaufman and I, on behalf of the committee,
16 wanted to thank our colleagues from Air Medical TAG
17 who joined us today as we begin to review and collate the
18 data that was received from Air Medical TAG study on
19 helicopter appropriateness.

20 We have identified our goals to go forward as
21 identifying the flight programs that did not respond to our
22 request for data, to review the data that he did receive for
23 the answers to the questions that we posed with regard
24 to the utilization and why folks are requesting medivac

1 operations, to provide feedback to their medical carriers
2 and their respective program agencies and REMSCOs and
3 then to revisit in the future.

4 We will work with our colleagues on the Air
5 Medical TAG between now and December to generate a
6 draft report which will be released to you at the
7 December meeting for ongoing discussion.

8 Bureau staff gave their report and we learned from
9 Ms. Geiger that there is no new information to share with
10 us yet on the state's quest to become NEPSIS compliant.
11 Despite a federal report that spoke to the contrary, New
12 York State has not signed on yet as a NEPSIS compliant
13 state but we are working in that regard. You will hear
14 about that in a minute.

15 It was reported that final edits are being made to
16 the '06 PCR data which the School of Public Health is
17 conducting some data analysis and we expect those to
18 be released shortly.

19 The request for information for electronic data
20 collection format is progressing. There is a document
21 that's being circulated throughout the Health Department
22 for review prior to its release.

23 That's the good news. The bad news is is that with
24 the budget issues being as they are it does indeed effect

1 the state RFP process. So, this RFI may be stalled
2 because we are not able to get an RFP for statewide
3 electronic data recording out the door because of the
4 budget issues.

5 Similarly, no news on the grant application that
6 was filed with the Governor's Traffic Safety Board. Those
7 funds, if awarded, would be used for the State Health
8 Department to contract with the consultant to work with
9 the state to achieve NEPSIS compliance.

10 To achieve -- to look at an infrastructure for
11 receiving electronic data from multiple regions across the
12 state, to assist regions in establishing electronic formats
13 and to work with regions as they pilot applications
14 towards NEPSIS compliance.

15 It was made very, very clear that funds would not
16 be used to provide hardware to any regions with regard to
17 electronic data reporting, but rather just to build the
18 infrastructure to receive electronic reporting format.

19 It was reported that there is ongoing collaboration
20 with the STAC to issue a revised trauma report which
21 would contain 2003-2006 trauma registry data, and it was
22 reported on working with the School of Public Health,
23 continued work with the School of Public Health and the
24 EMS receipt program to draft revised pediatric patient

1 care report to identify pediatric care capabilities across
2 the state. We expect that to come out early next year.

3 A lot of activity with regard to continued
4 partnership with New York ASEP, and Dr. Kaufman has a
5 comprehensive report on that for you as well today.

6 DR. KAUFMAN: Thank you. First, the National
7 ASEP is working on their next report card of emergency
8 care in the United States. They had sent out a request for
9 data to all the states and Bob and the bureau worked to
10 obtain some of the data and answer the questions as best
11 we could.

12 There was back and forth and a very successful
13 exchange, is what we are hearing from the ASEP. They
14 are very pleased with the data we provided.

15 The National ASEP report card is planned to be
16 released this December, so at our next meeting, maybe
17 after our next meeting, we will be able to review the next
18 version of the National ASEP report card.

19 We continue to work within the state on our joint
20 SEMSCO, SEMAC, New York ASEP report card on the data
21 points we previously identified within the state. It's been
22 an excellent collaboration. We have had a number of
23 meetings -- small group meetings -- since the last
24 meetings here.

1 We have moved ahead on a number of the data
2 points. In the near future there will be a survey going out
3 to the REMSCOs correcting some of the data on the
4 previously identified data points in regards to some of the
5 medical control -- the medical direction issues and the
6 protocol issues, specifically with pain control and certain
7 other questions regarding medical direction.

8 The survey is currently out as far as looking at
9 some of the issues involved in EMD and the PSAPs around
10 the state.

11 And on another data point, we have been working
12 with New York ASEP to cross reference the medical
13 directors, all the EMS medical directors within our state,
14 with the ASEP membership, to see how many EMS
15 medical directors are ASEP members and to see how that
16 coordination can work better in the future.

17 I think those are the key points. We will have more
18 data hopefully coming in the next couple months. Our
19 plan is to have the ASEP report -- the New York ASEP
20 SEMSCO report card released in May 2009 in conjunction
21 with EMS Week. That would be the recommendation we
22 would have.

23 MR. DELAGI: Thanks. Our last item of business is
24 follow up to the QI manual. It's been a little over a year

1 since the manual was distributed and we began to
2 conduct our rollouts, so as an ongoing work item on that
3 project we had wanted to put together some sort of a
4 survey so that we can gauge the success of the rollouts
5 and the success of the manual as it relates to regions and
6 agency specific QI programs.

7 So, our thought was to develop a very short survey
8 that we could distribute to the rank and file EMS
9 providers as they visit the SEMSCO/SEMAC booth at Vital
10 Signs in October, and our goal would be to have some
11 questions to gauge, from a provider vantage point, their
12 understanding of the QI process and responsibilities,
13 whether or not they have been introduced to the new
14 manual, what's happening at the agency level in the form
15 of QI, if QI findings are making their way back to
16 providers and making their way into the educational
17 component through their CME course offerings and the
18 like.

19 Our thought was on this: If we ask the agency
20 leadership to identify their programs they will all say they
21 have one because they don't want to be found to be in
22 non-compliance with the Public Health Law.

23 So, we wanted to do it from the ground up and find
24 out what the providers know about this. So, if there are

1 no objections to doing that, we have already spoken with
2 Don Faeth, as the Chairman of the Peer Committee, and it
3 looks like a very doable thing for us to put together a
4 survey and get it distributed at the Vital Signs
5 conference.

6 MR. WRONSKI: If you -- two things. If you put a
7 survey together we do need to approve it prior. That
8 won't be hard to do. Keep it simple because the more
9 questions you ask the less likely they are to give it back
10 to you. You obviously know what's your question, what
11 do you really want to know.

12 The other is is the work product in hand, so that
13 presuming a thousand people fill the survey out, someone
14 at one end is going to have to enter this data. So you
15 want to have some way to do this in a computerized
16 fashion as much as possible. So some simple way of data
17 entering it later.

18 MR. DELAGI: We are a very dedicated committee.

19 MR. WRONSKI: Great. That's great. The only thing
20 about your report, I just want to make clear, I think you
21 got it right, but I want to make sure everybody
22 understands.

23 New York State is moving towards NEPSIS
24 compliance. There's no doubt about that. We made that

1 decision internally. The formalized signoff process,
2 working with the national body to formally say New York
3 is a part of it is not finished, but we are certainly moving
4 in that direction.

5 One of the NEPSIS officers at a national meeting
6 announced that New York is now a NEPSIS state. That
7 was based on a hallway discussion I had with a federal
8 officer say, yeah, we are going to do it.

9 So, just so you know. We are going to do it. This is
10 our goal but it hasn't -- all the Ts aren't crossed. All the
11 dots -- the I's aren't doted.

12 MR. DELAGI: That's the end of the report, sir.

13 DR. MCEVOY: Could I just ask you -- I'm not sure if
14 I understood this properly.

15 You can't introduce -- you can't send out an RFI
16 because you can't do an RFP or you can't do an RFI
17 because of budget cuts?

18 MR. DELAGI: I think -- if Marjorie is in the room,
19 please back me up on this if you can, maybe you can, Ed
20 -- but my understanding was -- is that the RFI has been
21 drafted and it's going to interdepartmental review, but
22 because of the budget constraints looming that will
23 ultimately affect the RFP process, we may never get to
24 the RFI leading to an RFP and being put out to the

1 communities to consult on this project.

2 MR. WRONSKI: Right. First step is RFI. We have
3 written that. We do have it in the pipeline, but I believe --
4 and I would have to check with Marjorie on this -- but I
5 believe what probably happened is with the budget
6 crunch -- this doesn't mean money has been cut or
7 anything. It just means all the rules are off, we are
8 squeezing down, being told not to spend money, etc.

9 So, RFIs typically mean we want to spend some
10 money. So, basically I believe there has been a generic
11 rule out there except for things that are urgent must
12 happen for the public health and good, you are not going
13 to issue any RFI right now until we know there's going to
14 be money available to do anything with it. Otherwise it's
15 kind of a waste of time. So, I am sure that's what has
16 occurred.

17 MR. DELAGI: He said that much better than I did.

18 DR. HENRY: Okay. Thank you. Any other
19 questions or discussion? From the education committee,
20 are there any motions to come before us today?

21 DR. MCEVOY: There weren't any motions. I might
22 just mention one conundrum that was talked about quite
23 a bit. That's the new educational standard that is going
24 to come out of NTSA soon.

1 Here's the conundrum in a nutshell. The state
2 exams are based on objectives. What is coming out is
3 standards with no objectives. That poses a problem for
4 the state exam to move forward in that the objectives
5 now are going to be written by the textbook publishers,
6 and that's not really necessarily the best way to create a
7 state exam.

8 So, what is happening at this point is the education
9 committee has divided up the various curricula and asked
10 members to review the standards that are now available
11 against the current objectives and see what changes we
12 may perceive need to be made in the state's curricula as
13 they exist presently.

14 That's the beginning process which we can do now
15 because we have the standards available to us and you
16 will probably hear some more of that as we move forward.

17 So, aside from that, there was not anything of great
18 note to report.

19 MR. WRONSKI: Just one quick comment. The
20 national changes, we are looking at probably three years
21 down the road to have them actually in place.

22 So, I think -- I applaud the education committee to
23 start to look at these kinds of issues now while we have
24 some time to react rather than three years down the road.

1 DR. COOPER: It is my understanding, unless
2 something has changed in the last several weeks, that
3 the National Association of EMS Educators and National
4 Highway Traffic Safety Administration, which are
5 conducting this project, plan to create and have created
6 at least a draft set of guidelines that will bridge from the
7 current national standard curricula to the national EMS
8 education standards.

9 The preliminary drafts of those guidelines that I
10 have seen look awfully like the national standard
11 curriculum in many ways. So, at least for some period of
12 time I think there will be some guidance available.

13 And before the education and training committee
14 invests its limited resources in a wholesale creation of
15 objectives, competencies and so on, it might be
16 appropriate to review the guidelines and see if they will
17 serve the role that is needed.

18 DR. MCEVOY: We do have those guidelines for
19 some of the curriculum. The problem with them, Dr.
20 Cooper, is that they are completely unvetted. Some of
21 them reflect the opinions of the folks that were hired to
22 write them. Others are simply nutshell type of material. I
23 think without anything that's vetted we really need to do
24 that.

1 DR. COOPER: I think that's true at this point but,
2 again, unless my information is incorrect, it is the intent
3 of the working group to vet those guidelines once the
4 standards themselves have been vetted.

5 And as Mr. Wronski points out, it's a good three to
6 five years away before we see these standards actually in
7 place and really guiding EMS education in this country on
8 a large scale.

9 MR. WRONSKI: What I will do is -- I still think it's a
10 good idea. I had requested that Karen ask the education
11 committee to form subcommittees to look at these things
12 so that we monitor them.

13 I didn't expect they would write what we need over
14 the next couple of months. What I expected is they were
15 looking at the national materials, see what's there, see
16 where it's headed.

17 I will be at the national meeting this year. I know
18 they will be going over a lot of this, so I will bring back
19 what I can on what they plan to do, and what their time
20 frames are, so we can kind of manage what we do in the
21 education committee and how much work we do there.

22 DR. MCEVOY: We should be all done by December,
23 if you want to let them know we can give them our
24 material.

1 DR. HENRY: EMS staff report, please.

2 MR. WRONSKI: Just a couple of things. As
3 everybody knows, the state budget is not in good shape.
4 I mentioned that before.

5 How will this affect our work at the state level with
6 you? That's yet to be seen. What will happen is any
7 meetings we hold will have to be doubly vetted as to need
8 and how we hold them and where we hold them is going
9 to be scrutinized. How we feed you will be scrutinized.
10 What we feed you probably will be scrutinized. And all to
11 bring the budget down.

12 While I have not instituted it yet it has been
13 recommended to all councils, all state agencies, that for
14 their councils is that food should only be supplied to the
15 membership of these councils and not the guests and the
16 other participants.

17 Right now we have had a fairly open policy on this
18 so down the road we may have to modify and change
19 that. Internally what's occurred is that waivers we have
20 had for a number of vacancies we have had in the bureau
21 have been frozen, and that includes EMS reps as well as
22 clerks and secretaries we have vacancies for.

23 We have to repute in arguments to fill those
24 positions. And it's not just, again, EMS. It's every single

1 bureau, every single division in the Health Department
2 and the Labor Department. All of the state agencies.

3 How we use our state vehicles is being scrutinized
4 by me, as well as by others, so that we are limiting this.
5 You can send word out there to the ambulance services
6 they may see my reps less often. That might be
7 something they like, I don't know, although generally they
8 have a good relationship.

9 But we are -- it is serious, and we are looking for
10 every budget savings that we can. And to some extent
11 you will see some differences as we go along in your
12 meetings if this becomes a two or three year budget
13 crunch.

14 And my personal belief is that you are looking at
15 the long haul here and not the short haul, so I ask your
16 support as we move ahead and your understanding if we
17 don't have all the meetings you think we should have.

18 In regard, last time we talked about diversity. I
19 just want to briefly discuss that. Marjorie will be giving a
20 report on that tomorrow too.

21 We are continuing to try to identify membership
22 that will make our councils more diverse, and we have
23 asked the regional councils to also look at themselves,
24 how they are composed, how they look in relationship to

1 the communities they serve.

2 Are they a diverse council? Do they change
3 membership? And look at those issues, not just whether
4 or not you have an EMT or a paramedic on your service.

5 We are doing this at the state level, as I told you.
6 I'm asking your help, if you have -- suggest a delegate
7 who would meet the needs of council from a professional
8 standpoint or -- and a diversity standpoint, please give me
9 that name and make that recommendation.

10 I am continuing to look at the membership and how
11 it breaks out and where to make changes. I have
12 identified preliminarily four people who I will be bringing
13 onto the councils over the next few months. We are
14 continuing to try to identify some others. So, I ask your
15 assistance in that.

16 As you know, some members have had some of
17 their vetting process moving along. This does not mean
18 that all members are going to have their -- be vetted over
19 the next couple of months, but there is some movement
20 on a couple of people.

21 And one of the things I do want to make mention as
22 that as the vetting process reaches you or one of your
23 council's members it now includes the State Police
24 investigation. This would include fingerprinting and some

1 cases calling of references that you give.

2 This is all policymaking bodies. It's a new
3 requirement out of the Governor's office and it involves
4 not just EMS but all policymaking bodies. So I will say
5 briefly that one member was a little surprised when he
6 got a call, this is the State Police, you are under
7 investigation.

8 So they immediately put in that, by the way, this
9 has to do with your membership at a state agency
10 council. So it is routine, it has been done before at
11 certain levels of state government, but now it applies to
12 all policymaking bodies.

13 Two things went out that you should know about.
14 A Ryan White letter went out August 1st to all agencies
15 and services. It discussed the changes that federal
16 government dropped the pre-hospital or the emergency
17 provisions of Ryan White; however, we do have state
18 regulations in place that do provide some of the coverage
19 that Ryan White used to, specifically the coverage for HIV
20 in a process and an ability to get HIV exposure
21 information should you think one of your crew members
22 was exposed to HIV.

23 And the letter of August 1st discusses how that
24 would work, and how it's different from the former federal

1 requirement. Former federal process, remember, had the
2 designated officer. So, there is no designated officer any
3 longer supported by federal law.

4 My personal recommendation is that EMS services
5 that have a designated officer still in place keep them
6 because you can use that person to help you still manage
7 these issues, but the requirement in the state law
8 requires that the person who is exposed work with their
9 physician.

10 This can be an agency physician or a physician
11 identified at the hospital where you bring the patient.
12 You may or may not have HIV, and if you believe you have
13 had an exposure.

14 So I won't go through this letter, but any of you
15 who do not have it let me know and we will get it to you.
16 It was supposed to be sent to all members, I believe it
17 was, as well as to the regions, and it was both e-mailed
18 through counties and we sent hard copies of this in the
19 mail to all agencies in the state.

20 We have also shared this with the Office of Fire
21 Protection and Control and with DCJS Criminal Justice,
22 so that they can share it with police agencies and fire,
23 who are also affected by us. And this information is also
24 on our website.

1 Any questions on this?

2 DR. DAILEY: Mr. Wronski, just one brief thing.

3 I believe most of you got e-mails from me as the
4 legislative process went on last year and we hope that
5 we would get calls from the service station testing on
6 reading the requirements of New York State under the
7 law for the transmission -- or the transmission -- the
8 utilization of existing HIV information resources patients.

9 I can't think of a better sort of exclamation point to
10 our need to have more clearcut and easy pathways for
11 source patient testing and treatment of our providers.

12 I would like to, once again, thank this body for its
13 endorsement of the process that we are trying to make
14 state law, which would be clear pathways for easy source
15 testing.

16 I am continuing my efforts on behalf of multiple
17 different groups to try to get this one through the
18 Legislature. Hopefully now that we are getting closer to
19 election time we will have the opportunity, again.

20 Looked good over -- in the beginning of the summer
21 and then our hopes were dashed. Keep on trying. DOH
22 bill, actually that was -- is being brought forth by Gottfried
23 and Hannon actually looks quite good from our
24 perspective and we can hope for its success.

1 MR. WRONSKI: Second piece, MOLST, medical
2 orders for life sustaining treatment. The State
3 Legislature passed legislation on July 7, 2008, or that
4 may be the date the Governor signed it after the
5 Legislature passed it, but it was effective July 7, 2008.

6 It allows for an alternative form to the non-hospital
7 DNR. Sometimes that I think I have been guilty of what I
8 will call it the MOLST legislation. If you read the
9 legislation it doesn't say anything about MOLST.

10 What it says is the Department may use another
11 form. That was really the key. The current -- the statute
12 prior to that said that that non-hospital DNR, a form
13 approved by the hospital -- by the Department -- is the
14 only DNA form for pre-hospital.

15 Now MOLST may be used as an alternative form if
16 the healthcare systems in your region choose to do so.

17 So, it's an option to the existing DNR form. If they
18 put in place MOLST, it has a section for EMS on DNR. It
19 also has a section on DNI, do not intubate.

20 So, patients who are -- I think I have the language
21 here so you know -- patients found in progressive or
22 impending pulmonary failure without acute
23 cardiopulmonary arrest.

24 So, these are patients who you determine probably

1 need a tube and are about to go into cardiopulmonary
2 arrest. Their MOLST form has a section in there where
3 the patient can say, do not tube me in those cases. I do
4 not want to be intubated.

5 So, if they do, the ALS provider can make a
6 decision not to intubate that patient, and this is for the
7 MOLST form.

8 The only confusion I have heard on occasion is
9 does the MOLST form negate non-hospital DNR form. No.
10 If the patient has a non-hospital DNR form it doesn't
11 negate it. MOLST is an alternative to it.

12 I doubt you will see where patients today will have
13 both forms. They don't need both forms. MOLST by itself
14 is a stand alone. You may have areas where a patient or
15 the region and then in the healthcare system in that area
16 has not adopted MOLST as a process, so you may still
17 have a non-hospital.

18 We will be getting that information at the Vital
19 Signs Conference. I believe Mr. Bishop will also be giving
20 a short presentation at the education session to describe
21 MOLST in more detail.

22 There is a website, which I sent out in a
23 memorandum in July, that has been updated and gives
24 training on MOLST.

1 DR. COOPER: Recognizing that the new legislation,
2 as you correctly point out, refers to a form other than the
3 current prehospital DNR form, and recognizing that these
4 forms may end up looking a bit different, and that there
5 may be more than one form that is utilized at some point
6 in time, one can see the potential for possible conflict
7 between two forms on the same patient giving slightly
8 different direction to pre-hospital providers.

9 I do hope that whatever guidance is developed will
10 address that particular issue and make sure that some
11 simple statement, such as the document with the later
12 date or something along those, is the document which
13 will be binding. But I do think that there could be some
14 confusion now that the law is going to allow more than
15 one form.

16 MR. WRONSKI: Let me clarify. It has to be
17 approved by the Department. We are not going to
18 approve any other form. We have approved the MOLST
19 and we have approved the non-hospital DNR.

20 Having said that, things change. But all our work
21 has been with MOLST along with Blue Cross Blue Shield,
22 Excellus, and Dr. Bomba. They are going to go out, as Dr.
23 Bomba has, and they are going to promote their process.

24 So, you should only see these two forms, the

1 MOLST or the New York State non-hospital DNR, but it's
2 really going to be up to your healthcare providers and
3 hospitals in your region what they want to do.

4 Just one last thing. We are developing policy
5 within its final stages which will also be sent out to
6 everyone to describe some of this in more detail. I am
7 pretty sure it will ready before the Vital Signs Conference.

8 DR. VAN ROEKENS: Is there any move, as
9 previously requested, to require all nursing homes, long
10 term care agencies, to actually have this form or the
11 other DNR, DNI form as mandatory for their residents,
12 which would simplify the lives of every physician around
13 the table and actually improve the care, probably, and
14 decrease the costs.

15 MR. WRONSKI: I can tell you that there have been
16 meetings in which the executive -- some of the executive
17 leadership of the Department's division that oversees
18 nursing homes has been meeting with Dr. Bomba on the
19 form, etc.

20 Not quite sure what they are going to do with
21 nursing homes. I know they are going to educate them on
22 it. Whether they tell them you have to use this form or
23 exactly what's going to happen, I don't know yet, but I do
24 know they have been at the table to support the

1 implementation of the process.

2 DR. HENRY: Any other questions? Dr. Huffner.

3 DR. HUFFNER: Correct me if I'm wrong, but today
4 the only way to get a do not intubate order in the field in
5 New York State, though, is by using a MOLST. There is no
6 other way to get do not intubate or do not disturb an IV.

7 MR. WRONSKI: Right.

8 DR. HUFFNER: You have to use a MOLST.

9 MR. WRONSKI: Absolutely. It's clear on that.

10 If you have a do not -- if you have a non-hospital
11 DNR form, the standard one page New York State form
12 that you are all familiar with for many, many years, all
13 that says is do not perform CPR. It doesn't say anything
14 else.

15 The MOLST form is the only form that has a very
16 specific paragraph that says do not intubate me if I am
17 still breathing, so it's a little different. It's a more
18 complex form.

19 DR. MCEVOY: Dr. Huffner, you could also choose a
20 service after January 1st that doesn't have waveform
21 capnography.

22 (Laughter)

23 DR. HUFFNER: I thought about doing that but I
24 backed off.

1 MR. DELAGI: In response to that, the form
2 obviously is correct. It only makes reference to
3 cardiopulmonary resuscitation. But the supporting
4 document, 9310 I think it is, spoke very, very specifically
5 about not intubating somebody as they approach
6 cardiopulmonary arrest.

7 So there seems to be a disconnect in that at least
8 the way the old DNR form was interpreted one could not
9 intubate somebody in the prearrest situation based on
10 9310.

11 DR. HENRY: Not do the pulmonary resuscitation.

12 MR. DELAGI: Correct.

13 DR. HENRY: Just do the CPR.

14 MR. DELAGI: Right. I mean it even went so far as
15 to comment on the foreign body removal and having the
16 patient breathe on their own and things like that.

17 MR. WRONSKI: The MOLST form is much more
18 specific. It gives very specific guidance. Don't put a tube
19 in my throat. So, there is no question that it's not a
20 choice anymore. It's not a maybe.

21 It is if I am in those final moments -- and that's a
22 choice -- it's a tough choice the paramedic, the ALS
23 provider has to make because that is just the movement.
24 Then don't put that tube in me.

1 MR. DELAGI: It's just much more specific.

2 MS. CHIUIMENTO: I just want to comment: The
3 MOLST form actually gives an option. The patient can
4 say I want a tube or I don't want a tube. There's no
5 intubation of the tube either way.

6 MR. WRONSKI: I'm glad Sharon said that. Please
7 look at what the patient said that may have said no to
8 just save my life.

9 DR. HENRY: Is there any unfinished business?

10 DR. HASSETT: Just an item from the last meeting.
11 I had raised a question about the fact the manufacturer of
12 the Mark 1 kit will no longer -- is no longer manufacturing
13 them and is replacing them with the Duo Dote. And I just
14 ask this body if they were going to approve the
15 replacement of the Mark 1 kit with the Duo Dote, and we
16 never really did get an answer on that at the last meeting.

17 DR. HENRY: That's right. I was looking over the
18 minutes. I think Dr. Gonzales said he was aware of that,
19 they were coming out, it's not out yet. Is it out yet?

20 DR. HASSETT: It's out.

21 DR. HENRY: It is out. So, the protocols would be
22 similar, that it wouldn't impact on atropine alone because
23 that's one without Paradoxine.

24 They are packaged in the same dosage, correct?

1 DR. HASSETT: Yes, correct. The other difference
2 is you can't administrator one without the other in the
3 Duo Dote. It's a one shot.

4 MR. WRONSKI: I think the answer is we are going
5 to have to investigate it.

6 DR. HENRY: Sounds like it's covered. Instead of
7 two syringes you are using one, so the protocol would
8 remain the same, the same medication.

9 MR. DELAGI: I think it was really just more of an
10 administrative clean up that the current protocol made
11 reference to a Mark 1 kit and this is new device.

12 It's the same medicine, the same dosing, the same
13 route of administration, the same everything. Just
14 making reference to the different packaging.

15 DR. HENRY: If you put the generic drugs down
16 there would be no confusion. Refer to it as Mark 1 it
17 could be confusing, right? That's why New York City
18 made it purposeful about cleaning up their mid-level
19 agreement, right?

20 DR. KAUFMAN: Exactly right.

21 DR. HENRY: With the dosage 600 milligrams.

22 DR. KAUFMAN: That's right.

23 DR. HENRY: Do you want to comment on that? I
24 mean is it -- do you see a need to act on this or do you

1 think if we can interpret it--

2 DR. KAUFMAN: No. I mean in New York City we
3 chose to use -- to describe the dosage by atropine and 2
4 PAM, to coordinate so that those agencies that still have
5 plentiful supplies of the old product will be able to use
6 those and those with the Duo Dote will similarly be able
7 to use the Duo Dote based on the dosing.

8 MR. WRONSKI: Can I ask that you share any of the
9 documents the City's put together on this for some
10 guidance with me?

11 DR. KAUFMAN: Sure.

12 DR. HENRY: What I would recommend we do, and
13 chip in if you think differently, is that wherever we talked
14 about Mark 1 make sure we have the words atropine and
15 Paradoxine with the dosages next to the Mark 1 kit.

16 So whether, as Brad said, you have the older
17 package or the newer package, it's clear by generic drugs
18 what the treatment is. That should take care of it. If you
19 don't have the Paradoxine you give the atropine dose
20 alone, so for those who people who just have the atropine
21 we will be clear.

22 MR. WRONSKI: What I will do is I will pull out the
23 state policy on -- the old state policy on the Mark 1's and
24 look at that in relation to this and maybe we will issue a

1 letter just letting areas know how we view this. But for
2 this table, I think it's -- unless there is other questions.

3 DR. HENRY: Is that clear enough? Okay. Any
4 other unfinished business? I asked Dr. Funk in the
5 interim if there is any word further from the blood council.
6 But not yet since our last meeting.

7 MR. WRONSKI: No, but Dr. Linden has done some
8 additional work, and just recently sent us that, so there is
9 a movement.

10 DR. HENRY: Any other unfinished business? Any
11 new business? Dr. Fairbanks.

12 DR. FAIRBANKS: I just want to bring up an issue to
13 the group just for guidance, I think more for a problem we
14 have been having. I don't want to bring this decade old
15 problem up again but it's just for guidance.

16 The C spine protocol has been great and we
17 commend everybody on getting it through after all the
18 work and it's been wonderful, typically having the training
19 that accompanies it.

20 Our region is moving forward, but some of the main
21 Train the Trainer programs brought an issue to our
22 REMAC that I don't have a good answer for and I just
23 want to get guidance.

24 That is that although we did a good job to keep the

1 protocol kind of keep it simple stupid, very
2 straightforward and the Power Point presentation that the
3 education committee developed is consistent with it,
4 there is -- published on the website there is a curriculum
5 that I don't remember seeing, but I wasn't at the last
6 meeting.

7 But it is much more involved and detailed in terms
8 of the assessment. And the way it's created problems for
9 us in our region is that we are training BLS providers to
10 do this C spine selective clearance, or whatever the
11 correct term is for it, selective normalization.

12 However, there are some exam -- physical exam
13 tests that are in this curriculum published by the
14 Department of Health that are probably above what we
15 should expect from our BLS.

16 And I read some of them to you. Test intraosseous
17 muscle function controlled by the T-1 nerve roots. Have
18 patients spread fingers of both hands and keep them
19 apart while you squeeze the second and fourth fingers.
20 Test the extensors of the hands and fingers controlled by
21 the C-7 nerve roots.

22 So, my concern is that this curriculum being
23 published creates a standard of care and I am concerned
24 about the liability. And I guess what I hoped to do in our

1 region was keep it a little bit more general, but the
2 protocol is -- it says do a neurological exam to test for
3 function.

4 So, I guess I'm seeking guidance. I'm not sure
5 where this came from or what its purpose is. And the
6 question is: Do we need it and is it useful to us?

7 DR. HENRY: I don't know if anyone has an answer.
8 I will refer this for further investigation. I am glad you
9 brought it up.

10 MR. WRONSKI: Where did you pull it down from,
11 the DOH website?

12 DR. FAIRBANKS: It's actually pretty
13 straightforward. From the main site under operations
14 there's -- the second bullet is New York State EMT Basic
15 Life Support and ALS Protocols -- I'm sorry -- Basic Life
16 Support Protocols updated 6/3/08. If you go to that link --
17 I am off line now.

18 (Laughter)

19 DR. FAIRBANKS: I think I can remember it. If you
20 go to that link there's something that says C spine
21 clearance protocols and under that there's a subheading
22 that says curriculum and it's the PDF that comes up.
23 Page 13 is where this neurological assessment guidance
24 starts.

1 MR. WRONSKI: We will pull that, look at it.

2 DR. HENRY: Any other new business?

3 DR. VAN ROEKENS: Our region had a lengthy
4 discussion around the interface between Article 28 and
5 Article 30 related to EMS providers bringing in patients
6 that might be unstable, particularly emergency
7 departments that might be staffed with sole provider or a
8 small outpost critical care hospital.

9 And the concern is that under the hospital law the
10 EMS providers are not to be providing any type of care at
11 all. And this is similar to the blood issue.

12 Ultimately providers around the table wanted the
13 right thing to happen for the patient, which may include
14 using the resource of that EMS provider to continue CPR
15 to assist.

16 I just want to put that out there that while we don't
17 want -- we are not going to condone the practice of -- the
18 ongoing practice in the Department without the hospital,
19 prehospital personnel, that's a gray zone, and we want to
20 make sure that we bring it here and any advisory we want
21 almost purposely vague so they allow the right thing to
22 happen.

23 MR. WRONSKI: In any reviews we have had over
24 the years, and there's been a number of cases we had

1 where pre-hospital continued some care in transferring
2 over to the hospital.

3 For us, the issue of an EMS crew showing up with
4 an emergency patient who needs care, and it's not
5 available at the hospital, and the hospital says we need
6 your help, okay, and you continue it until such time as the
7 hospital can assume care.

8 We are not going to cite a hospital, or -- well, we
9 are not going to cite prehospital. Potentially, depending
10 on why the hospital didn't have something maybe they
11 should have had, we might wind up citing a hospital. The
12 key really is the hospital itself.

13 The hospital is looking for your assistance in this
14 hopefully brief period of time, right, where you are
15 assisting with the patient. I don't think anybody
16 questions that. What it can't be is that there is a routine,
17 agreed to, prehospital will be providing care to our
18 patients typically when you arrive.

19 That becomes problematic, but I don't think there
20 is an issue in a gray area you talk about, where you are
21 delivering a patient continued care until we can turn that
22 patient over.

23 I agree these problems exist, particularly in those
24 out stations where you might have a PA backed up by a

1 nurse who might have three or four patients that night for
2 whatever reason. How do they deal with this? I don't
3 want -- I would rather not see EMS crew turn and go out.

4 DR. COOPER: I think Dr. Van Roekens is making a
5 good point. And perhaps in the protocol revision process,
6 which is currently underway, some statement might be
7 made in the general operations suggestion that providers
8 are expected to continue care until relieved by the
9 appropriate hospital personnel, something along those
10 lines. That would, I am sure, solve the problem. Words to
11 that effect.

12 DR. VAN ROEKENS: At the same time, just for
13 clarification, I am not -- the agencies and the whole
14 personnel are not -- I'm not trying to create problems for
15 agencies where the hospitals aren't providing the care
16 they should.

17 I'm talking about these incidents where there is an
18 average census of 12 patients, 15 patients, 30 patients,
19 and then suddenly there's an overwhelming emergency
20 and are called upon to use the resources available to
21 deliver the appropriate care at the appropriate time, and
22 that might include having the EMS personnel continue
23 CPR.

24 MR. WRONSKI: And the other -- I have had specific

1 complaints made to my office that -- from the other side
2 of the coin -- hospitals, not many, but it has happened, are
3 keeping our crews.

4 And our crews are afraid to leave because they are
5 saying this patient needs nursing bedside or let's get a
6 doctor and nobody is there. And we don't want to leave,
7 but they are not coming and my crew's been there for a
8 half hour with this patient with lines in, etc., and they
9 have asked me what to do.

10 I said, well, you need to meet with the hospital
11 CEO on this. You really need to bang at the high door and
12 see if you can work this out so it doesn't happen in the
13 future.

14 If that doesn't work then you need to write a formal
15 complaint to the Department of Health and have the
16 Bureau of Hospital Services investigate it and they have
17 the ability to force staffing changes in that hospital to
18 make things occur.

19 If it's not the exception to the rule. If it happened
20 to you one Thursday and the only time it happened was
21 that Thursday all year, take a deep breath, but sometimes
22 it's happening much more often.

23 DR. HUFFNER: This isn't going to allow you to have
24 EMS do the discharge instructions. There's a clear

1 differentiation. There is a slippery slope. There's a very
2 slippery slope when the expectations are that
3 understaffed ED needs are somehow being met by EMS.

4 Recall that EMS has other requirements outside
5 the ED, and that is a very slippery dangerous slope.

6 DR. VAN ROEKENS: That's the primary obligation.

7 DR. FAIRBANKS: We have three hour waits right
8 now. Three hour waits in Rochester routinely. So, just to
9 emphasize what a huge issue this can be.

10 MR. WRONSKI: Three hour waits before the crew's
11 free?

12 DR. FAIRBANKS: Before the crews are given a bed
13 so that they can leave their patients.

14 DR. HENRY: Dr. Funk.

15 DR. FUNK: I want to thank you for giving me the
16 opportunity to once again ask about the specialty care
17 transport task force question.

18 While this may be considered a rarity and a
19 problem and something that doesn't happen on a regular
20 basis on the delivering end, on the picking up end of an
21 interfacility transport, sometimes having the
22 out-of-hospital provider be the one to provide the skills is
23 the best thing for the patient.

24 They may be the most experienced person to do

1 the pediatric IV, the neonatal intubation, the adult central
2 line, whatever it is that needs to get done for that patient
3 to stabilize them for an interfacility transport.

4 It may be the interhospital team as the best
5 provider to do the job, the most experienced provider to
6 do the job, or the one who is most comfortable with it.
7 And it happens on a regular basis. It's not an intermittent
8 thing.

9 I have data from just my own service that shows
10 that we do plenty of procedures before we put a patient
11 into the transport vehicle because it needs to get done
12 that way.

13 It is a gray zone. We talked about it here before.
14 My paramedics perform procedures inside hospitals
15 because it's necessary for patient care to make them
16 safe for the transport.

17 That's not allowed, but we have taken care of that
18 -- we have taken responsibility for that patient. Yes, that
19 hospital still has responsibility and if we were to do
20 something wrong they certainly would have some
21 ownership for it, but they put their trust in us by calling us
22 to care for that patient.

23 I think that this isn't --it's a need. We see it in our
24 service. We see it in our own hospital. I am sure you all

1 do also.

2 I would suggest, again, that we ask to see sort of a
3 multi-disciplinary group put together from -- with
4 somebody from hospital services, somebody from EMS,
5 somebody from the Department of Education, because
6 those are all the participants in rulemaking of this sort, so
7 that we can talk about the issue as it exists and figure
8 out a way to make it not a gray zone, to make it not a
9 shhh, it happened again kind of issue, but put some
10 regulation behind it and make sure that it's getting done
11 appropriately. And that the paramedics who are
12 performing these procedures are not only credentialed
13 but they have the authority to be doing the things that
14 they are doing and get the appropriate training for it.

15 DR. VAN ROEKENS: Here here.

16 DR. HENRY: Any other new business?

17 DR. TAKATS: I think that it's pretty obvious that
18 there are many issues that we have gone over and over
19 here informally and formally without really any
20 implementation of any changes, but the consensus of the
21 membership is that there are certain things that should
22 be moving forward or moving forward quickly.

23 I think a problem that we have is this onerous and
24 absolutely painful requirement to change protocols or

1 change policies or change -- or implement new drugs with
2 this concept of demo project and pilot projects,
3 especially when there is either national recognition or
4 universal or medical recognition that what we are talking
5 about here is already acceptable practice either all over
6 the country or mostly all over the country.

7 And the fact that we have to go and reproduce data
8 that has been reproduced multiple times in multiple
9 places all across the country, I mean it doesn't make any
10 sense.

11 We have to develop some kind of a short circuiting
12 method to provide for implementation for some of these
13 projects, I mean whether it's our STEMI project, whatever
14 it is, there are lives out there, there is dangerous
15 situations out there that we can assist if we could move
16 more quickly and more efficiently by developing a
17 creative concept.

18 DR. HENRY: I think there is some creativity. I
19 mean in the City they have partnership agreements with
20 hospitals. They don't designate them. They have
21 partnership agreements. That's what Dr. Freese said last
22 time.

23 So, given the cumbersome nature of regulations
24 and whatnot, somehow some places find ways to do

1 things that are common sense.

2 DR. TAKATS: In the western region we had an
3 official -- Health Department official tell us a partnership
4 between an ambulance company or an agency and a
5 hospital was unacceptable.

6 DR. HENRY: They move with all deliberate speed,
7 but some things get done. Some things get done like we
8 acted on today, and they have far reaching implications,
9 so there is deliberation, but I hear what you are talking
10 about.

11 I think what Dr. Funk is talking about are practices
12 that have taken place before this council was even
13 formed. You had specialty units from hospitals going out
14 to get burn victims, high risk, all the services that in the
15 appropriateness review standards for both new services
16 or specialized patients that came into existence because
17 some places did them and then they got written in code.
18 And for most of those children or adults with those needs,
19 teams were sent out from institutions who could care for
20 them to bring them back and care was delivered at those
21 services.

22 So, that's -- the common sense of this has taken
23 place for a long time. If the bodies are right, the
24 regulations in Article 28 and Article 30 can't get it right in

1 language, that's a secondary problem. I don't think the
2 intent was ever to stop the practice because that's the
3 origin of this, as I recall it.

4 DR. TAKATS: You are talking about credentialing
5 of paramedics within the hospital --

6 DR. HENRY: You have unions that make actions
7 with State Ed because they don't want paramedics
8 working in a job description that might threaten them, so
9 therefore they get an interpretation that you can't have
10 people working side by side in the hospital. That's the
11 reality of what things have happened. If they read the
12 fine print of the regulation, they can read it that way.

13 DR. TAKATS: But if a hospital should desire to
14 credential the medical staff, decided to credential
15 paramedics to perform a certain service, irrespective of
16 the Health Department's certification which says they
17 can only work under certain circumstances, be it in a
18 hospital or where there is an active course being
19 conducted.

20 I don't think that there's anything that would
21 prevent a hospital from credentialing those people as
22 long as they made their own job description, as long as
23 they approved of the individuals practicing in that way.

24 MR. WRONSKI: Just a comment on that since it

1 has been an issue with the Department. The hospitals
2 can take any individual and ask them to do certain things,
3 and either train them that way or they have already got
4 the training and credential them, you are capable of doing
5 this, go ahead and do it.

6 Where the problem comes in is you pass a certain
7 line and that line is considered then the practice of
8 medicine by an unlicensed provider. That's where the
9 gray zone is. Where is that line in any given instance?

10 And the line is not typically pointed out by
11 Department survey. It is typically pointed out by fellow
12 licensees in the hospital, either an MD, RN, PA, some
13 other licensed individual says, that person is doing
14 something that's the practice of medicine and shouldn't
15 do it here, and writes a formal complaint typically to the
16 State Education Department.

17 And that's where these issues come up. And the
18 State Education Department has made it clear you have
19 to be a licensed individual to do certain things each time,
20 whatever they do. Somebody has to interpret whether
21 that's in fact the practice of medicine and the hospital
22 has no right to allow them to do that without a license,
23 and that's the issue.

24 DR. COOPER: Mr. Chairman, we all know that this

1 debate has been going on for many years, will likely
2 continue to go on for many years, and we can't at least
3 solve it here and now.

4 But it has been sometime since this issue has been
5 formally vetted. And while I won't make the motion, I will
6 ask that the Chair consider putting a work group perhaps,
7 as Dr. Funk suggested, to perhaps reconsider this issue.

8 The specialty care group, I think that Dr. Funk has
9 lead, has indicated that when the appropriate parties get
10 around the table, while progress is slow, progress can be
11 made. I think we have that foundation to work on.

12 Dr. Funk has constructed a very nice platform for
13 us to move to another level. Perhaps it is time for us to
14 reconsider that issue again now in light of that history
15 and the vast changes that have taken place in medical
16 practice since the last time we looked at this issue.

17 MR. WRONSKI: I am going to suggest you shouldn't
18 put a committee together because Dr. Funk did a lot of
19 work and there's a lot of information already there. It's
20 already done really.

21 What needs to occur, if this is agreed, is you should
22 ask the Chair to pose a letter formally to the
23 Commissioner and say to us that we support what, and
24 lay it out. We would like an appropriate committee to be

1 put together with State Education to look at the issue.
2 And we would have to consider that.

3 DR. COOPER: That's all I am asking.

4 MR. WRONSKI: Okay. I didn't know that. I can tell
5 you it's a very difficult issue, and I do not know whether
6 or not State Education is willing at this time to sit down
7 and discuss this issue. They may not want to. They may.
8 We can ask.

9 I had previously talked to the Bureau of Hospital
10 Services and had planned to do some work on this. We
11 have not done that for a variety of reasons.

12 But, certainly, if you want to push the point that's
13 the way you push it. Write a formal letter saying you
14 really want this done because we see it as really
15 important to do, but I don't think another necessarily
16 working committee is going to happen.

17 DR. FUNK: I would agree that another working
18 committee would not be useful at this time. The
19 Specialty Care TAG has been stalled because there's
20 nowhere else to go.

21 I understand that the educational component
22 specialty care group has also stalled because there's
23 nowhere else to go. We can't go anywhere else without
24 people -- hospital services, patients -- joining together

1 with us because EMS alone can't do anything about
2 taking care of interhospital patients without them.

3 So, this letter very well might just mirror the letter
4 that the past council Chair sent in December of last year
5 to the Commissioner requesting a task force be put
6 together to look at the entire interfacility transport issues
7 as Article 30 demanded that we all do.

8 Maybe we should just copy it and send it again to
9 both the council Chair and medical advisory committee
10 Chair, and maybe if we send it enough times it will get to
11 the top of the list one day.

12 MR. WRONSKI: Remember, there was a response.
13 The initial response was the Commissioner thanked the
14 committee for its work, suggested that it work on the
15 similar things where we can.

16 But you certainly can raise it again and say we are
17 doing that moving ahead but this particular -- and I would
18 focus it. I wouldn't give a list of 12 or 20 things. I would
19 focus it. This particular issue is important and it's our
20 understanding that we and the Department of Health need
21 to be at the table together.

22 DR. COOPER: Let's do it. So moved.

23 MS. BETTS: Colleen Betts, Emergency Nurses
24 Association.

1 I just want to say that we have had many heated
2 discussions at the EMA meeting about this topic. Several
3 times I wished I had a flack jacket on.

4 You have nurses downstate that are so strongly
5 opposed to this that it's going to be very difficult to make
6 any progress with the Education Department. They are
7 afraid the paramedics and prehospital providers will take
8 their jobs.

9 That is their biggest concern. So, they got a big
10 union. They got a big voice.

11 DR. BRODERICK: Just add another -- a caution to
12 that. I am just concerned, and we see it in our local level,
13 that being an EMS agency that was taking patients out of
14 critical access hospital to tertiary care centers. That
15 that agency really didn't have that amount of training.
16 Insisted that they develop that.

17 The hospital's issue was that we don't have the
18 ability to provide that care; thereby kind of relying on
19 some EMTs to provide that.

20 I don't want to advocate their duty, which is to
21 make sure that at that hospital they have a trained
22 professional that will provide that. My concern is a little
23 bit is that they could say, oh, good, the transporting
24 agencies are going to provide the service. Therefore, we

1 will have somebody we pay at a lower level and just have
2 them do the basic stuff and therefore we will be saved
3 consistently by an agency.

4 I want to make sure hospitals do not have that out,
5 and that is a concern especially with the constraints that
6 are existing out there, especially in New York State.

7 DR. FAIRBANKS: I am not as up on the issue, so
8 you can tell me, if it's the case everyone around this table
9 feels that it's time for another -- a new revitalized push on
10 licensure of paramedics, then maybe that's the letter that
11 we should write rather than having the letter be focused
12 on interfacility transports.

13 I think that in an organized fashion EMS could have
14 a lot of very powerful counterpoint to the nursing lobby,
15 including many states, but Virginia, I spent seven years in
16 Virginia, EMS providers can do their skills in the hospital,
17 they work in the hospital, physically it makes a lot of
18 sense.

19 Hospital based ambulance services have
20 paramedics in the hospital giving tetanus shots when
21 they can and there's still a nursing shortage in Virginia.
22 So, there's not a problem. I am sure there is other states
23 we could look at.

24 I think we in EMS, if we really want to hold our

1 heads high and be the professionals that we know we
2 are, we need to organize and have a very organized
3 response to the lobby that's against this.

4 So, my recommendation would be that instead of
5 focusing just on interfacility, that we focus on the
6 licensure issue that would make the interfacility problem
7 go away.

8 DR. FUNK: I don't know that it will make the
9 interfacility problem go away. The entire transport
10 system is not defined at all right now. That needs to be
11 defined.

12 Having the paramedics licensed is just part of that
13 issue, that's for sure, but it would raise a lot of other
14 issues.

15 The transport system needs to be addressed
16 because you can license paramedics, but if you are not
17 going to mandate the training and the procedures that
18 they perform during interfacility transport, and the
19 regulations supporting that, doesn't do you any good for
20 the patient being moved between hospitals.

21 I can't disagree that having paramedics licensed
22 would solve some of the issues that we are talking about.

23 DR. HENRY: While hearing this, I think it's probably
24 worthwhile to compose a letter to the Department asking

1 to get together with State Ed. There's a new
2 administration. Perhaps there's an opportunity to take
3 advantage of that fact and to work towards some
4 common sense.

5 The interpretations that have been made in the
6 past year or two on this issue have pushed things
7 backwards, in my opinion. Just robbed people of training.
8 It's not in the public interest.

9 I am sure the people who issued these
10 interpretations didn't intend that. It happened. But, so
11 we will take the feeling of the group to advise and we will
12 try to compose one.

13 Any other new business?

14 MR. ZEEK: Just a reminder to the group that the
15 licensure TAG did make a strong recommendation that
16 there be an interdepartmental task force developed or
17 assigned to look into licensure.

18 And I also wonder if -- I think this letter is a good
19 idea, but I wonder if we shouldn't request actually a
20 meeting with a number of people with the Commissioner
21 to really face to face go over the issues so that he is
22 thoroughly versed in what the problem is so that he can
23 then go to the Department of Education or assign
24 somebody to liaison with the Department of Education.

1 DR. HENRY: I guess our first job would be to
2 succinctly write it in a couple pages or less so it's clear,
3 to get some clarity on exactly what we are asking. If we
4 have trouble I will ask Dr. Dailey, the English teacher, to
5 help us.

6 DR. FUNK: Since he's not here we will assign it to
7 him.

8 (Laughter)

9 DR. VAN ROEKENS: Before we get into the next
10 time we are all going to meet as a group, I guess I would
11 ask that we consider asking the Commissioner to send a
12 letter to hospital CEOs about the practice of boarding and
13 keeping in patient patients in the emergency
14 departments, which impacts the EMS services as well as
15 the care of all patients. So, putting that duty back on the
16 hospital, if you would.

17 MR. WRONSKI: Just to let you know: There is a
18 letter being drafted, and I believe will contain that, but
19 you certainly can support that.

20 At the last meeting of the trauma regulation group,
21 two weeks ago Dr. Mully asked for a letter from STAC in
22 support of what they have seen. So, there is a
23 Department letter that is going out. So, sure, that letter
24 will be fine.

1 DR. HENRY: Any other new business? Next
2 meeting is December 2nd. We are going to have -- Dr.
3 Marshall is going to represent us tomorrow at the
4 SEMSCO.

5 And take a motion to adjourn. All in favor.

6 (Ayes recited.) Meeting is adjourned.

7 (Meeting adjourned.)

