
NEW YORK STATE
EMERGENCY MEDICAL ADVISORY COMMITTEE
(SEMAC)

Joseph Takats, MD
Edward Wronski
Greg Young
Mark Zeek

Tuesday, February 17, 2009
1:30 p.m.
Crowne Plaza
Lodge Street
Albany, New York

APPEARANCES:

Mark Henry, MD, Chair
Sharon Chiumento
Arthur Cooper, MD
Michael Dailey, MD
Jack Davidoff, MD
Robert Delagi
Phyllis Ellis, RN
Terry Fairbanks, MD
John Hassett
Timothy Haydock, MD
William Huffner, MD
Bradley Kaufman, MD
August Leinhart, MD
Lewis Marshall, MD
Raquel Martin, DO
Michael Mastrianni, Jr
Michael McEvoy, PhD
Daniel Olsson, DO
Valerie Ozga

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1 DR. HENRY: I'd like to
2 take a roll of members present.
3 (Roll call was taken.)
4 DR. HENRY: Okay. Thank
5 you. As we open the meeting, I'd
6 like to stop for a moment to
7 remember two in the EMS community
8 who have died recently. And I'd ask
9 Mr. Wronski and Dr. McEvoy, in turn,
10 to make some comments.

11 MR. WRONSKI: The EMS
12 community has lost two valued people
13 in our EMS community. Dr. McEvoy
14 will give us some information, some
15 personal information, about the
16 second person.

17 The first person that I'll
18 mention is Mr. Mark Davis. Mr.
19 Davis was an EMT for only a couple
20 of years - two years - in the north
21 country of New York State. And he
22 is, to our knowledge, outside of the
23 9/11 event, the only EMT in New York
24 State who was, in fact, murdered in

1 the line of duty, killed by a
2 patient who became aggravated during
3 a call and shot at crew.

4 And Mr. Davis was killed on
5 the spot. The bullet cut his aorta
6 and did other damage, so he died on
7 the spot. He was twenty-five years
8 old and had been an EMT for, I
9 believe, just a little over two
10 years.

11 In talking to people from the
12 community, he was very well liked.
13 He was very positive. And what I
14 was told was he was the type of EMT
15 who loved his patients. He enjoyed
16 giving care to people and that was
17 why he was a paramedic student and
18 was working towards becoming a
19 paramedic.

20 We, at the request of the EMS
21 community, did issue Mark an
22 honorary paramedic certificate
23 signed by the Commissioner, but more
24 important than that -- and that was

1 important to his family, I was told
2 -- was the turnout. And there was,
3 apparently, a six mile long
4 procession at his funeral. And the
5 only reason that occurred was
6 because the EMS community from the
7 surrounding counties all pulled
8 together and provided ambulances to
9 cover for the local communities
10 where Mark worked. And so they were
11 able to cover all EMS calls during
12 that time in a rural community that
13 doesn't have much to spare, but this
14 allowed all the local members of the
15 EMS community to attend Mark's
16 funeral.

17 So in a moment, I'd ask for a
18 moment of silence, but I now ask Mr.
19 McEvoy to talk about the second loss
20 to the community.

21 DR. MCEVOY: I would like
22 to ask just for a moment of
23 remembrance for our colleague, our
24 friend, student, teacher and really

5

1 on the pile in the City.

2 Subsequently, in his own
3 words, John "could not sit home and
4 drink a beer knowing that there were
5 young soldiers who needed a trauma
6 surgeon in Iraq." He responded by
7 joining the U.S. Army Medical
8 Reserve Corps, and less than a month
9 into his second tour as a combat
10 surgeon, Major John Pryor gave his
11 own life in service to others. He
12 left behind a wife, Dr. Carmella
13 Calvo, three children ages four,
14 eight and ten, his parents, and his
15 brother Richard, a local emergency
16 department physician.

17 While saddened and heartbroken
18 at the loss of such a young brother,
19 colleague and friend, we are also
20 proud, proud of the upbringing that
21 each of us in this room, I think, is
22 responsible for giving this loving
23 father, this dedicated husband, this
24 skilled surgeon, gentlemanly

7

1 a true American hero, Dr. John Paul
2 Pryor, who was the trauma director
3 for the hospital of the University
4 of Pennsylvania in Philadelphia, who
5 was killed in Iraq by an enemy
6 mortar on Christmas morning 2008.

7 John was a member of the
8 Pennsylvania SEMAC. He was an
9 editorial advisor for the Journal of
10 Emergency Medical Services and on
11 the board of directors of the
12 Greater Philadelphia chapter of the
13 American Red Cross.

14 He was born and raised in New
15 York State. Dr. Pryor was attracted
16 to medicine by volunteering at
17 Clifton Park-Halfmoon Ambulance just
18 a few miles north of here. He
19 finished medical school and his
20 surgical residency at the University
21 of Buffalo, and like many New
22 Yorkers, John was deeply influenced
23 by the September 11th attack on
24 America. He spent two days working

6

1 teacher, and as I said before, true
2 American hero.

3 While incomprehensible to many
4 people, I think those of us here
5 today know exactly what John Pryor
6 was doing in Iraq and why he went
7 there.

8 As a soldier, we salute Dr.
9 Pryor. As a physician and surgeon,
10 we seek to emulate him and as a
11 human being, we honor his memory and
12 rededicate our own lives, I think,
13 in the spirit of service to others
14 as he has taught us.

15 May he rest in peace and may
16 God watch over his loved ones.

17 MR. WRONSKI: So if we
18 could have just a moment of silence.

19 (Whereupon, a moment of
20 silence was observed.)

21 MR. WRONSKI: Thank you.

22 DR. HENRY: We'll seek
23 approval of the minutes from the
24 last meeting in December. Are there

8

1 any notes or -- yes.
2 MS. CHIUMENTO: Just a
3 few. Page 4, line 21, MHTSA should
4 be "N" like in Nancy H-T-S-A. Page
5 90, line 4, N-A-M-S-P should be
6 N-A-E-M-S-P. And then Mr. Van
7 Roekens should be Dr. Van Roekens on
8 page 98, line 12, page 90, line 24
9 and page 58, line 19.

10 DR. HUFFNER: With those
11 corrections, move to approve.

12 DR. HENRY: Is there a
13 second?

14 DR. TAKATS: Second.

15 DR. HENRY: All in favor?
16 Opposed? Abstentions? Carried.

17 Okay. Is the Monroe County
18 alternative destination program --
19 we were going to have a report on
20 this. I understand it may be moved
21 to our next meeting?

22 MR. WRONSKI: That's
23 correct. I don't know if Tim is
24 here to say something.

9

1 other members of the consortium that
2 had put this together who had wanted
3 to add things to the presentation
4 that they believed were important
5 for you to understand and so he
6 needed to delay this until the June
7 presentation. Otherwise, he was
8 prepared today. So this will be
9 back on the agenda in June.

10 DR. HENRY: Thank you.
11 We'll go to our reports of the
12 standing subcommittees.

13 The first one, education. Is
14 there any reports or any motions to
15 come forward to the body? Dr.
16 McEvoy.

17 DR. MCEVOY: There is and
18 I'm going to do this from my memory
19 because my notes are buried in a
20 pile here.

21 The one motion to come forward
22 is to approve the PAD program by the
23 Wilderness Medical Associates and
24 that's been looked at by the

11

1 Just to -- I spoke to Mr.
2 Czapranski. He had prepared a more
3 detailed PowerPoint regarding the
4 Monroe and Rochester area project,
5 which we approved as a demonstration
6 project a little bit more than a
7 year ago, I guess to demonstrate, at
8 the ability of the EMS community, to
9 identify and move a patient to a
10 non-ED setting if their medical
11 condition warranted that. That
12 program is now over. It has ceased.
13 A letter was sent to the Department
14 a couple of weeks back indicating
15 that.

16 I had asked for a more
17 complete presentation here at the
18 SEMAC so that you could all
19 understand the successes and the
20 non-successes of the program and
21 what was learned in the slightly
22 more than a year.

23 Mr. Czapranski advised me
24 today that he had been contacted by

10

1 education and training committee and
2 does comply with DHA guidelines. So
3 I think it's a formality to bring it
4 here and then to move it forward.
5 So that's a seconded motion that
6 comes forward from training and ed.

7 DR. HENRY: Is there any
8 discussion? All in favor, raise
9 your hands. Opposed? Abstentions?
10 Carries.

11 DR. HUFFNER: Just for
12 clarification, that's a training
13 program so that they can teach PAD,
14 correct?

15 DR. HENRY: Correct.

16 DR. MCEVOY: Correct.

17 DR. HENRY: Do you have
18 anything else, Dr. McEvoy?

19 DR. MCEVOY: I think most
20 of the other discussion was
21 extraneous. There's work still in
22 progress on taking the new
23 educational guidelines and
24 translating that into what we're

12

1 going to use for curriculum here,
2 but there is considerable time with
3 which that needs to be done, because
4 none of the textbooks are going to
5 be ready for a couple years for
6 that. So that's in progress.

7 The safety TAG will report
8 separately and there was some
9 discussion about the use of online
10 education. And a proposal came from
11 the TAG to allow a little bit more
12 than is presently allowed in online
13 education as a component of the
14 continuing ed refresher program.
15 But there were so many questions on
16 that that it was tabled, so you'll
17 hear more about that once they get
18 some definitive action on it.

19 DR. HENRY: Okay. Thank
20 you. Any questions for Dr. McEvoy?
21 Okay. I'd like to move to the
22 Medical Standards protocol
23 committee, Dr. Marshall please.

24 DR. MARSHALL: Thank you.

13

1 first aid in pediatric protocols, a
2 note advising that sick children
3 should be transported immediately.
4 There should be no delay in
5 treatment because the way the
6 protocol reads, it could be
7 interpreted to mean that the
8 provider should stay on scene and
9 complete everything before beginning
10 transport and that was not the
11 intent of the region.

12 The adult CPR protocols,
13 changing CPR from one to two minutes
14 and also adding for the
15 administration of nitroglycerin in
16 patients who have been on ED meds.
17 Change nitroglycerin to seventy-two
18 hours instead of twenty-four hours,
19 so you wait with patients that have
20 been on ED meds, especially with
21 some of the newer ones lasting
22 seventy-two hours and having long
23 half lives, administering
24 nitroglycerin after seventy-two

15

1 We have just a couple items, action
2 items, this morning.

3 The protocol, med standards
4 protocol, met immediately before
5 this meeting this morning and we
6 have three action items that come
7 forward that are protocols.

8 The first one is mid-state and
9 ALS protocols and the proposed
10 motion you can see on the screen.
11 Mid-state ALS protocols were
12 accepted with the following
13 provisions: The inclusion of
14 physiological criteria from policy
15 0505 in terms of air medical
16 transport, removal of the maximum
17 dose of Ativan, protocols 4.6 and
18 4.17, which is pediatric airway
19 obstruction in unconscious patients.
20 Adding CPR -- initiation of CPR in
21 those protocols, Changing cycles to
22 time for CPR so that CPR will be two
23 minutes.

24 Also, in the beginning of

14

1 hours. You can call medical control
2 and override that for patients who
3 have had ED medications that are
4 shorter acting.

5 Protocol 3.6, Diltiazem should
6 not be used in Wolff-Parkinson-White
7 and that was included.

8 And in the pediatric neonatal
9 resuscitation, change the word
10 "lethargic" to respiratory distress
11 in regards to meconium aspiration --
12 aspiration of meconium is present.
13 And that's consistent with house
14 guideline.

15 There was also some other
16 discussion regarding skills training
17 -- skills and maintenance of skills
18 of all levels of providers. There
19 was a discussion about
20 inter-facility transports and having
21 a medication list of medications
22 that are being used during
23 inter-facility transports as part of
24 the regional formulary. And those

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1 were all discussion points.

2 In addition to that, the
3 committee recommends that regions -
4 not just mid-state, but regions
5 provide SEMAC with information on
6 additional training for all skill
7 levels and discuss in terms of how
8 those skills are maintained,
9 especially for inter-facility
10 transports.

11 But the protocol changes are
12 listed and they come forward as a
13 seconded motion, if anybody has any
14 questions.

15 DR. DAILEY: Actually, Dr.
16 Marshall, to clarify, I don't think
17 we actually suggested to remove the
18 maximum dose of Ativan. I think our
19 concern actually was that it was too
20 large a dose of Ativan and the
21 practice of the physicians around
22 the table was two to four milligrams
23 of Ativan, likely two milligrams of
24 Ativan -- two milligrams of Ativan

17

1 standards on the Ativan dosing?

2 DR. MARSHALL: Yes.

3 DR. DAILEY: Thank you.

4 MS. OZGA: What would you
5 like it changed to?

6 DR. DAILEY: Maximum dose
7 would be two milligrams and then
8 repeated every five minutes.

9 DR. HENRY: Is there a
10 second for that adjustment?

11 DR. HUFFNER: Seconded.

12 DR. HENRY: All in favor
13 of that amendment, raise your hands.
14 Opposed? Abstentions? Carries.

15 So with the seconded amendment
16 -- I mean, with the amendment, we'll
17 take the motion up. Call the roll,
18 please.

19 (Roll call vote was taken.)

20 MS. OZGA: Passes.

21 DR. HENRY: Thank you.

22 Dr. Marshall.

23 DR. MARSHALL: The next
24 action item is Suffolk protocols.

19

1 then repeated as needed.

2 DR. MARSHALL: Correct.
3 We did have that discussion. There
4 were several members who felt that
5 way, but I think at the end, it was
6 just to remove the maximum dose.
7 But I agree with your statement that
8 there was a discussion about how
9 much to be given, especially for an
10 adult patient. I think it listed
11 the maximum at ten to fifteen
12 milligrams.

13 MS. CHIUMENTO: The adult
14 CPR from one to two minutes actually
15 was the pediatric. However, now in
16 looking back, it also applies to the
17 adult. So both protocols need to be
18 changed from one to two.

19 DR. HENRY: All right.
20 Any other discussion? All right.
21 Can raise your hands for a vote on
22 this one?

23 DR. DAILEY: May we
24 actually adjust the motion from med

18

1 The Suffolk protocols were accepted
2 with the following amendments: In
3 the pediatric altered mental status
4 protocol, bottom of page 83, they
5 have a note regarding intubation and
6 they left out capnography. So that
7 will be included.

8 In the suspected cyanide smoke
9 inhalation protocol, use of
10 hydroxocobalamin for patients with
11 significant hypotension and/or
12 cardiac arrest as a standing order
13 as opposed to a medical control
14 option. And that was originally a
15 medical control option, but the
16 committee felt that in certain
17 instances, hypotension and cardiac
18 arrest, the delay to call medical
19 control is not necessary and that
20 the medication should be
21 administered at that time.

22 Again, with erectile
23 dysfunction meds, nitroglycerin will
24 not be given if the medication is

20

1 taken within seventy-two hours,
2 again with the proviso that medical
3 control can override that. Those
4 were the protocol changes.

5 And the committee also had two
6 recommendations. The first
7 recommendation, the committee
8 recommended -- the committee
9 strongly recommends that all ALS
10 agencies be capable of carrying and
11 using controlled medication for
12 treatment of certain patients,
13 particularly those such as seizures
14 and pain management. And that was
15 also approved by the committee.

16 And another recommendation was
17 the use of technology to detect
18 carbon monoxide, that regional
19 resources for hyperbaric oxygen
20 therapy be evaluated and included in
21 regional protocols when available.

22 DR. HENRY: All right.
23 Any discussion? I will call the
24 seconded motion. Dr. Dailey.

21

1 detecting technology will be
2 available.

3 MR. DELAGI: Did we miss
4 this earlier that there is a
5 reference to obtaining the SPCO
6 reading under standing orders?
7 That's actually in there.

8 DR. MARSHALL: It is. It
9 is in there.

10 DR. DAILEY: Do you have
11 that under your smoke inhalation
12 protocol? I thought you didn't have
13 a smoke inhalation protocol.

14 MR. DELAGI: Well, we
15 didn't. We came here today with a
16 suspected cyanide/smoke inhalation.
17 We're taking the recommendation to
18 make them two separate protocols,
19 and of course we will include the
20 SPCO reading in the smoke inhalation
21 protocol.

22 DR. DAILEY: Perfect.

23 DR. HENRY: Dr. Fairbanks.

24 DR. FAIRBANKS: And I have

23

1 DR. DAILEY: Just to
2 clarify for the purpose of the
3 motion, I believe, actually, the
4 intention was that if they were
5 going to have -- and Mr. Delagi, if
6 you could just make sure that I
7 don't misstate what we talked about
8 -- but that the intention was that
9 the smoke inhalation protocol
10 reflect the technology for the
11 detection of carbon monoxide be
12 available at the same time as the
13 hydroxocobalamin, at the same scene.

14 DR. MARSHALL: My mistake.

15 MR. DELAGI: That is
16 correct. And it will be added to
17 the current policy for use of the
18 non-invasive cholecystectomy that we
19 recently put into place.

20 MS. OZGA: So which one
21 should I change, Dr. Marshall?

22 DR. MARSHALL: Suspected
23 cyanide smoke inhalation, and after
24 standing order, that carbon monoxide

22

1 one concern that - I apologize - I
2 wasn't able to bring up at med
3 standards. But the Toradol -- just
4 from a safety issue, the Toradol
5 dose IV thirty and IM sixty. One
6 recommendation from a safety
7 standpoint is to make your doses the
8 same and there's not a lot of
9 evidence to show sixty makes a big
10 difference over thirty IM. So one
11 thing to consider might be to keep
12 it at thirty.

13 If not, I mean -- my overall
14 recommendation would be you don't
15 need Toradol. You've got much
16 better pain relievers on board. But
17 if you're going to have Toradol, try
18 to -- I would recommend you keep the
19 dose the same for IM and IV.

20 DR. HENRY. Okay. Well, that
21 was a personal recommendation.

22 DR. MARSHALL: Toradol --
23 Toradol was discussed in terms of
24 pain management, but there was no

24

1 recommendation by the committee to
2 accept or reject the current one
3 that the region had in place, which
4 was thirty IV or sixty IM. But we
5 did discuss it in terms of its
6 efficacy.

7 DR. HUFFNER: They don't
8 have any other alternative pain
9 medicines, correct?

10 DR. FAIRBANKS: Fentanyl
11 and Morphine.

12 SPEAKER: It depends on
13 the agency.

14 DR. MARSHALL: Correct.
15 Yeah. The discussion was about
16 agent -- availability of all ALS
17 agencies in the region to have these
18 medications and they don't. So the
19 regional council put in -- I
20 believe, put in Toradol as an
21 alternative medication for those
22 agencies that don't carry narcotics.

23 DR. FAIRBANKS: The
24 concern I'm raising is if a provider

25

1 DR. HENRY: Okay. Any
2 other discussion? All right. We'll
3 call the question. Take a vote,
4 please.

5 (Roll call vote taken.)

6 MS. OZGA: Passes.

7 DR. HENRY: Okay. Thank
8 you. Dr. Marshall.

9 DR. MARSHALL: Yes. One
10 more action item. Mountain Lakes
11 region has one protocol brought
12 forward on pediatric anaphylaxis and
13 it really amounts to wording
14 changes. Under EMT intermediate,
15 there's a line that says, "If unable
16 to contact medical control" and then
17 it talks about if less than thirty
18 kilograms, administer epi pen junior
19 or epi pen. So they left out if
20 it's above thirty kilograms. So
21 they're going to put that back in.
22 So it will say, "If below thirty
23 kilograms, give epi junior. If
24 above thirty kilograms, give regular

27

1 has it in their head -- sixty may be
2 in their head and it could be a
3 normal error to give sixty IV, which
4 would, you know, hurt the kid,
5 usually. So the safety would be to
6 have thirty be the standard dose
7 that everyone thinks of when they're
8 thinking Toradol.

9 MR. DELAGI: I don't see a
10 problem with taking that back and
11 having the REMAC look at that. It
12 certainly does appear like a
13 friendly amendment that is easily
14 acceptable.

15 DR. DAILEY: I think the
16 intention of the committee this
17 morning was to make sure that when
18 Suffolk brings back their next set
19 of protocols, that they focused on a
20 county-wide system to assure,
21 indeed, that every agency be capable
22 of treating seizures in a child or
23 an adult, as well as pain
24 management.

26

1 epi pen."

2 And the second was in the
3 medical control option, there is a
4 bullet which talks about
5 administration of an epinephrine
6 drip. And so they're going to put
7 the word "drip" in that line in the
8 second bullet. And that was
9 approved and comes forward as a
10 seconded motion.

11 DR. HENRY: Is there any
12 discussion? Okay.

13 (Roll call vote taken.)

14 MS. OZGA: Motion passes.

15 DR. HENRY: Thank you.
16 Dr. Marshall, did you have other
17 items to talk about?

18 DR. MARSHALL: We did have
19 other things to discuss, and perhaps
20 I can discuss some of them here.

21 One of them was the statewide
22 ALS standards, the regulations that
23 would require REMACs to create their
24 protocols and conformity with state

28

1 standards. So we're going to need
2 to move forward with that. There
3 was a draft that we will send out.
4 Sharon had put it together, so we'll
5 send that out for the committees to
6 take a look at.

7 There was also some letters
8 received and phone calls received
9 regarding treatment of patients with
10 congenital adrenal hyperplasia in
11 the prehospital setting and
12 encouragement from organizations for
13 EMS to include Solu-Cortef in terms
14 of treatment of these patients in
15 the prehospital setting.

16 We had some discussion about
17 this and reviewed the letters that
18 were received from one group, which
19 is the CARES Foundation, and the
20 fact that most systems have some
21 steroid available, whether it's
22 Hydrocortisone or Decadron in the
23 prehospital setting and perhaps that
24 can be used.

29

1 you for giving me a few minutes to
2 speak to you today.

3 My name is Debbie Brown and
4 I'm a board member of the CARES
5 Foundation. And the CARES
6 Foundation is an organization that
7 advocates for patients in families
8 affected with congenital adrenal
9 hyperplasia. I'm also the mother of
10 a daughter, a treatable daughter
11 with congenital adrenal hyperplasia,
12 and a registered nurse.

13 I'm here today to urge you to
14 include injectable glucocorticoid
15 treatment of individuals affected by
16 adrenal insufficiency in New York's
17 statewide emergency response
18 protocols.

19 What if I told you I had a
20 miracle drug that could prevent
21 shock, heart failure and cardiac
22 arrest? Well, I do have a miracle
23 drug and it's called Solu-Cortef.
24 It is not new, but among individuals

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1 I think we'll probably need to
2 look at this more in terms of about
3 whether or not it should be included
4 in a state standard, but certainly
5 regions, I think, would be available
6 to look at this on a regional level
7 and determine if they want to put it
8 in the regional protocols.

9 I don't know if you have
10 anything else to --

11 MR. WRONSKI: Sure. What
12 I would like to ask, is there anyone
13 in the audience from the Foundation
14 to represent this issue that is here
15 today? We were told there might be
16 somebody -- yes. Why don't you come
17 forward to the microphone right at
18 the end? And if you could identify
19 yourself and then give a short
20 presentation about this issue and
21 what you're asking the SEMAC to
22 consider?

23 MS. BROWN: Sure. Well,
24 first of all, I want to thank all of

30

1 affected with adrenal insufficiency,
2 it's our miracle drug.

3 Upon injecting Solu-Cortef in
4 an adult or a child in an adrenal
5 crisis, something miraculous does
6 happen. The child that looks ashen
7 and unresponsive suddenly begins to
8 have color and talk. The mother who
9 is vomiting and feels as if she
10 might faint suddenly feels better
11 and the patient in cardiac arrest
12 begins to respond to intervention.
13 Yes, this is our miracle drug.

14 For a course factor of \$4.65 a
15 vial and a shelf life of four years,
16 Solu-Cortef is not only lifesaving,
17 but cost-effective and easy to
18 administer.

19 You must understand that when
20 adrenal crisis comes on, it comes on
21 fast. I have seen this with my own
22 daughter. She has gone from
23 responsive and alert to barely
24 responsive and bluish-gray in

32

1 fifteen minutes. With no time to
2 spare, just a half of ml of
3 Solu-Cortef has done the trick
4 within minutes. Shock and cardiac
5 arrest were averted and I'm here
6 today to tell you that she is fine.

7 This is just my story, though.
8 There are many others that have not
9 been as fortunate. Others have
10 endured long hospital stays,
11 permanent disability or death due to
12 lack of prompt treatment with
13 Solu-Cortef.

14 You all, as the medical
15 advisory board, can help change
16 that. You have the ability to
17 change protocols so that when
18 someone is found unconscious due to
19 adrenal crisis, you can save them.
20 When EMS arrives at a scene with
21 frantic parents and a child who is
22 already blue from adrenal -- and a
23 child who is already blue from
24 adrenal crisis, EMS can help.

33

1 and those with some pituitary
2 disorders. These conditions leave
3 patients at risk for adrenal crisis.

4 My daughter wears a
5 medic-alert bracelet, something a
6 recent CARES Foundation survey found
7 seventy-five percent of our members
8 do. These measures, however, will
9 do nothing to save her life if she
10 becomes ill or is injured and we are
11 not there with her or if we become
12 incapacitated due to an accident.
13 Current EMS protocols in New York do
14 not address special needs, much less
15 adrenal insufficiencies.

16 Finally, I want to mention we
17 have a willing community of
18 endocrinologists eager to provide
19 training in this, as well as policy
20 development. While I realize there
21 are costs associated with change,
22 looking at the whole picture, I
23 think it's fair to say that one
24 hospital admission for an adrenal

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1 I have constantly been
2 reminded where I live on Long
3 Island, a hospital is only five
4 minutes away. I agree, but five
5 minutes may be five minutes too long
6 when an adult or a child is severely
7 ill from adrenal crisis.

8 There is a reason that
9 endocrinologists are training
10 parents to administer Solu-Cortef,
11 as well as providing prescriptions
12 to parents. There is no time to
13 waste. We are not on chartered
14 territory as far as protocols go.
15 Rhode Island has in place protocols
16 to treat adrenal insufficiency
17 already. Here in New York, we can
18 too. And by the way, these
19 protocols have not only assisted
20 2,000 people who suffer from CAH in
21 New York. This is just the tip of
22 the iceberg. You would also help
23 patients who have had
24 adrenalectomies, Addison's patients

34

1 insufficiency, should it develop,
2 shock, heart failure or cardiac
3 arrest is likely to exceed the costs
4 of implementing these changes.

5 On behalf of New York's
6 children and families, I urge you to
7 help keep the adrenal insufficient
8 safe by adding injectable
9 glucocorticoids in New York's EMS
10 formularies, as well as adding the
11 necessary prehospital and transfer
12 protocols statewide. The power to
13 save lives is in your hands. I
14 thank you for your time today.

15 And I just wanted to mention,
16 we were all just in the Family
17 Advisory Network newsletter, the
18 cause that we're working towards for
19 glucocorticoids. I also have a lot
20 of information to hand out.

21 MR. WRONSKI: We
22 appreciate that. What I would ask
23 the chair is that we not finalize
24 any discussions today, but we take a

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1 look at the material and make a
2 decision. Our decision -- actually
3 the SEMACs decision and the State
4 council's decision is whether it
5 makes sense to write an actual state
6 protocol, deliver this information
7 to the regions and potentially do
8 this as an educational effort across
9 the state so that EMS knows what
10 this condition is, what the
11 treatments are and then let regions
12 handle this individually, which they
13 have the authority to do. Or do we
14 -- do we modify, actually, a state
15 protocol.

16 But this information will help
17 and we'll certainly look at it. But
18 I'm going to ask the chair if
19 there's anything else -- if he may
20 have any questions.

21 DR. HENRY: I thank you
22 for your presentation, too, and
23 we'll direct this to the Medical
24 Standards committee. Is there any

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1 know, what is the clinical
2 appropriateness of using Solu-Medrol
3 for a patient in crisis?

4 DR. HENRY: Well, there is
5 more than one steroid that one can
6 use to meet the needs and I think
7 that's why it's useful to refer it
8 to Medical Standards committee and
9 review this in depth and people
10 bring their - you know - regional
11 perspectives and we can seek
12 expertise and some more data. Dr.
13 Dailey.

14 DR. DAILEY: What may be
15 very appropriate from this body, at
16 this point, though, would be for us
17 to endorse the assistance of parents
18 with giving this medication should a
19 parent present EMS with this.

20 It's glucocorticoid. Most of
21 the regions that I know have
22 corticoid steroids - excuse me - on
23 their protocols. Therefore, we're
24 not assisting with a medication that

39

1 --

2 MS. BROWN: Thank you.

3 MR. DELAGI: Actually,
4 just one question, if you don't
5 mind. I'm particularly interested
6 in this case, because I learned
7 today that the author is from my
8 region and we do have a history of
9 trying to provide focused education
10 and training to patients with
11 special needs and other things, as
12 long as we are consistent with the
13 scope of practice for those
14 providers.

15 I'd like to get the sense of
16 the SEMAC for a minute, if that's
17 okay. In the discussion that we had
18 earlier this morning, it seemed as
19 though Solu-Medrol, a medication
20 that we do already carry, may be of
21 benefit in these types of cases.
22 But I see the note in the letter
23 where it specifically references
24 Solu-Cortef. And I'm not sure, you

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1 our providers don't have some
2 knowledge of, even though not of
3 this specific drug. And, indeed, it
4 is a drug that will make a profound
5 difference to a child in crisis.

6 So it would come down to
7 assisting a parent or a patient in
8 using their own medication that they
9 supply. Certainly, while Medical
10 Standards is looking at this as an
11 issue statewide.

12 DR. HENRY: Are you
13 talking at the BLS level?

14 DR. DAILEY: That would
15 probably require additional training
16 for the BLS providers, but for
17 intermediates, critical care techs
18 and paramedics, who are well aware
19 of how to give injections, it would
20 be --

21 DR. HENRY: I agree, the
22 procedure is known, but many times
23 when we teach this, there is the
24 indications and what to look for and

40

1 I don't know that those are included
2 in our training, specifically, for
3 this purpose.

4 DR. DAILEY: My suggestion
5 would, actually, be assisting the
6 patient or the parent, who supplies
7 you with the drug and says, "I'm in
8 crisis. My child is in crisis. I'm
9 incapable of giving this shot.
10 Please help me." And I think that
11 we should look to our providers and
12 give them the support to let them
13 help their patients.

14 DR. HENRY: Is this with
15 the medical control consult or on
16 their own, because I think if it's
17 on their own, my feeling is we
18 should make sure they know the
19 indication they're doing it for, so
20 we're just consistent as we would be
21 with other purposes.

22 DR. DAILEY: We talked
23 about this before.

24 DR. MCEVOY: I'd be a

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1 patients at risk for adrenal crisis
2 and 2,000 with this specific
3 condition.

4 MR. YOUNG: Point of
5 clarification. That's all age
6 groups, is it not?

7 MS. BROWN: Yes.

8 MR. YOUNG: That's not
9 just for the CAHs, that's for all
10 the Addison's?

11 DR. HENRY: My feeling is
12 we ought to move this to committee,
13 have a thorough discussion about it,
14 find out how many cases have
15 presented prehospital, what's
16 happened, how we can best do this in
17 a safe manner and I'll direct the
18 discussion to the next Medical
19 Standards. Yes, Sharon.

20 MS. CHIUMENTO: I wonder.
21 The EMS-C is meeting next month.
22 Would you like them to look at this
23 and make a recommendation?

24 DR. HENRY: Well, I think

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1 little bit curious. I don't know if
2 the speaker is aware of, like, what
3 the incidence of this is statewide.
4 I know we have one child in my
5 county of a quarter million who
6 we've programmed that information
7 into our CAD to make sure that they
8 get the right medication, because
9 the glucocorticoid that she was
10 mentioning is not the one that we
11 carry.

12 MS. BROWN: The incidents
13 of CAH are 2,000 in New York, but
14 then again, there are other
15 conditions --

16 COURT REPORTER: I can't
17 hear you.

18 DR. DAILEY: She said
19 2,000 patients a year.

20 MS. BROWN: And the
21 estimate is 12,000 patients at risk
22 for adrenal crisis and 2,000 with
23 this specific condition.

24 DR. DAILEY: 12,000

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1 Medical Standards should be the
2 point. If they want to give input,
3 they can, but I want the discussion
4 to be at Medical Standards. All
5 right. Dr. Marshall. Dr. Cooper.

6 DR. COOPER: I do think
7 that Ms. Chiumento's point is
8 worthy of consideration. We do have
9 an Emergency Medical Services for
10 Children advisory committee and this
11 is an issue that has major pediatric
12 implications.

13 So I think a discussion at the
14 next meeting of the EMS-C advisory
15 committee would be -- would be
16 appropriate, but I share your view
17 that ultimately the decision needs
18 to be made at Medical Standards and
19 at SEMAC.

20 DR. HENRY: Dr. Marshall.

21 DR. MARSHALL: Okay.

22 We'll make sure that all the
23 information gets distributed so
24 people can have a chance to review

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1 it before the next meeting.

2 We also discussed online
3 medical control. We actually had a
4 presentation from EMS-C regarding
5 online medical control for cases of
6 pediatric cases and they did a
7 survey, which was a federally-funded
8 survey, I believe, and they had
9 quite a significant response rate of
10 80.7 percent. So 80.7 percent of
11 agencies responded to the survey,
12 which was very good.

13 I think that some of the --
14 that there's a lot of confusion out
15 there about what medical control is.
16 I think that was one of the issues
17 that came up, and possibly the way
18 the questions were worded and the
19 way people understood the questions
20 in the survey may have affected the
21 outcome. But certainly I think it
22 illustrates that there is a need for
23 us to clarify medical control and
24 online medical control for all

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1 paraphrase that -- I don't know
2 exactly how they said it, but that's
3 what it sounded like. So if the
4 receiver knew more than the caller,
5 then that person was okay to provide
6 medical control. There was a lot of
7 discussion on both sides on whether
8 it should be a physician, whether it
9 could be a nurse practitioner or
10 physician assistant and we're going
11 to continue those discussions.

12 Part of -- one of the issues
13 that our state policy 9501 requires
14 is that online medical control must
15 be provided by a physician.
16 However, the state regulation
17 provides that medical direction be
18 provided by a physician or under the
19 direction of a physician. So
20 there's some conflict there. So
21 we'll be working on that in the
22 future.

23 There was also a survey done
24 by the QA in terms of the region and

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1 patients in New York, not just
2 pediatric patients, but for all
3 patients and who is providing online
4 medical control.

5 There was also information
6 from a survey done by the Office of
7 Rural Health regarding rural
8 hospitals and critical access
9 hospitals in New York State and
10 their provision of emergency medical
11 services, who's on duty in the
12 emergency department, is it a
13 physician or a PA or a nurse
14 practitioner, how many hours a day
15 do you have physician coverage and
16 whether or not these hospitals
17 provided online medical control and
18 who was providing that online
19 medical control.

20 I think one of the things that
21 came from the EMS-C survey was that
22 the federal accepted medical control
23 was somebody who knew more than the
24 caller. You know, if I could

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1 whether or not -- what are the
2 regions doing in terms of online
3 medical control. And it was
4 interesting to see that not all
5 regions are all doing the same
6 thing. There are regions that have
7 PAs and nurse practitioners that are
8 providing online medical control in
9 certain circumstances and in certain
10 regions. And regions have made this
11 decision based upon the needs of
12 their region and the resources that
13 they have available.

14 So one of the things we need
15 to consider when we talk about this
16 in the future is what resources are
17 available, if we're going to require
18 a physician contact for online
19 medical control considering
20 hospitals, especially critical
21 access hospitals and rural hospitals
22 that may not have a physician
23 available to provide online medical
24 control. And if you want them to

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1 call somebody else in another part
2 of the state, whether or not that
3 other online medical control
4 facility would be willing to accept
5 online medical control from another
6 area of the state that they have no
7 relationship with.

8 And so these were some of the
9 issues that were discussed this
10 morning, as well as technological
11 issues and some of the legal issues
12 in terms of online medical control.
13 And so we'll be discussing that
14 further.

15 We also noted that the CDC has
16 issued the field triage guidelines,
17 which I believe Dr. Cooper and Dr.
18 Henry participated in. So if
19 anybody would like to review those,
20 feel free and we would like
21 comments. And if you have anything,
22 you can submit them and we'll pass
23 them on to the State Trauma Advisory
24 Committee.

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1 transfusion or would it just be for
2 their home hospital.

3 So there is some language
4 clarification that needs to be
5 addressed, also, in addition to the
6 medical director of the service and
7 if they can provide direction to
8 administer blood or blood products.
9 Is that the ambulance service
10 medical director or is that the
11 transfusion service medical director
12 within the hospital, and there are
13 different interpretations of that
14 language. And we have some other
15 language. I don't know if you want
16 to comment about some of the other
17 --

18 DR. HENRY: Well, some of
19 the points where it talks about
20 forms approved by the Department.
21 So it would be nice to see what
22 drafts of those are the Department's
23 work and so we can give input on
24 that, too. The end game is to make

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1 There was some significant
2 discussion about proposed language
3 which would allow prehospital
4 providers and inter-facility
5 transport agencies to administer
6 blood and blood products outside of
7 the hospital. There is draft
8 language that has been circulated.
9 Everyone should have gotten it. If
10 you did, you should review that.
11 The department is looking for
12 comments. These comments, we are
13 requesting they be submitted by
14 February 27th. So you have ten days
15 to get your comments down in writing
16 and submit them.

17 The discussion this morning
18 had to do with a lot of things, but
19 particularly language which would
20 address contracts or agreements that
21 ambulance services would have to
22 have with a hospital, would it be
23 their transfusion center and would
24 it be with every hospital that has a

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1 blood available during transport to
2 people who need it. And I think we
3 should look pragmatically at the
4 regulations to make sure it answers
5 that need. And if you have queries,
6 I would urge you to forward them to
7 Mr. Wronski so that we can look at
8 the regulatory language and see if
9 it's enabling or if it needs a
10 little work to accomplish that goal.

11 So I believe it was broadcast
12 to the SEMSCO and the SEMAC members,
13 the information, so you should have
14 it. If not, let us know.

15 DR. MARSHALL: All right.
16 And that, I'm happy to say, is the
17 end of my report.

18 DR. HENRY: Any other
19 questions for Dr. Marshall or any
20 discussion on Medical Standards?
21 Hearing none, I'd like to move to
22 the Quality Improvement/Quality
23 Assurance, Mr. Delagi and Dr.
24 Kaufman.

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1 MR. DELAGI: Thanks, Dr.
2 Henry. We had our meeting earlier
3 today. We also did a little bit of
4 work since our last meeting and I'll
5 report on that to you going forward
6 now.

7 We learned from staff during
8 the report given by Ms. Burns that
9 the 2006 data disks have been
10 released and they're currently
11 working on the data processing and
12 keypunch vendors to get the '07 and
13 '08 data out at a faster pace.

14 We were asked to work with EMS
15 staff on developing, for lack of a
16 better term, I'll call it the
17 receiving format for electronic data
18 that's being submitted or generated
19 across New York State to be received
20 by the state.

21 You'll remember at our last
22 meeting, we reported on the awarding
23 of the NTSA grant. The first year
24 deliverable called for an RFA

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1 our last meeting, we developed the
2 executive summary to provide to
3 regional program agencies so that we
4 can elicit their continued help and
5 support in getting information about
6 quality improvement out to the
7 respective services. So that will
8 be going out there in the next
9 couple weeks.

10 We've asked an individual from
11 the hospital preparedness bureau to
12 come and visit our meeting in June
13 so that we can engage in some
14 dialogue about the QI process,
15 specifically with information
16 sharing between hospitals and
17 ambulance services and we are
18 looking forward to bringing that
19 project to closure.

20 We did take a look at the New
21 York report card, the ACEP report
22 card that was distributed and I know
23 you've all seen that. Of relevance
24 to our committee work is we

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1 process, which they reported they
2 received about seven or eight RFIs.
3 The purpose of that project was to
4 benchmark what the DOH is currently
5 doing now, surveying services to see
6 what's in place across the state, in
7 essence to identify the platforms
8 that people are using to file
9 electronic data so that the state
10 can develop a receiver of electronic
11 data to accommodate what everybody
12 is using. It sounds more
13 complicated than it is, I'm sure,
14 for those of you who understand
15 technology, but for me it's kind of
16 a stretch. So we're going to be
17 spending the better part of this
18 year and early next year in that
19 first year deliverable.

20 As a follow-up to our QI
21 process, you'll recall that we
22 developed and distributed that
23 survey. That was given out at the
24 2008 Vital Signs conference. Since

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1 identified twenty-two data points
2 that are related to EMS activity
3 that are worthy of further review.
4 And we're going to be taking that
5 project on over the next several
6 months and hope to give you a
7 preliminary report at least by the
8 next meeting in June.

9 We -- as part of the process
10 that we started with the air medical
11 TAG, we are actively looking to
12 engage a member of the STAC to sit
13 on our committee with the primary
14 purpose of seeing if we can develop
15 a pathway for sharing inpatient data
16 or emergency department data on
17 folks that were flown to trauma
18 centers that we identified in our
19 survey so we could take a look at
20 patient outcome.

21 One of the things that we did
22 talk about was EMS providers who
23 were very, very good at requesting
24 medi-vac services based on physical

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1 finding, anatomic criteria or
2 mechanistic criteria, but we really
3 don't have any idea of how sick
4 those patients were. So we want to
5 engage the STAC in trying to develop
6 that pathway for information and
7 that will ultimately lead to other
8 information sharing with regard to
9 the entire trauma system.

10 And then based on some
11 discussions that you've heard about
12 the online medical discussion, we
13 were one of the committees that sent
14 out a survey. We identified some
15 information that was fairly
16 consistent with everything else that
17 you heard this morning and we think
18 that there's a natural partnership
19 between our committee and the
20 systems committee to take a look at
21 online medical control, who's
22 providing it, how it's being
23 provided and so on.

24 And that is our report.

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1 of other localities are doing that,
2 not just in anticipation of the
3 state budget but their own, you
4 know, problems that they're having
5 right now because of the economy.

6 We're in no different shape.
7 Although the state EMS budget, as
8 far as I know to date, will be whole
9 for next year and there won't be any
10 cuts in it, there will be
11 limitations on how I'm allowed to
12 use it, what kinds of money I'll be
13 allowed to spend and I'll have to be
14 making more and more justifications
15 each time I do that. But at this
16 point, we see no real cuts in the
17 EMS budget.

18 I did mention at the last
19 meeting -- I believe I did, or maybe
20 it was at the STAC meeting, that
21 there are discussions to drop county
22 EMS funding. There is some money, I
23 believe about 1.6 million annually,
24 that goes to counties that support

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1 DR. HENRY: All right.
2 Any questions or further discussion?
3 Hearing none, we'll ask for the EMS
4 staff report. Mr. Wronski.

5 MR. WRONSKI: Welcome to
6 our first meeting of the new year
7 and good attendance. We're very
8 happy to see that. Just a couple of
9 things.

10 The state budget. Real quick,
11 and I reported to the State Trauma
12 Advisory Committee that there is no
13 new good news. The state budget is
14 something that is still in
15 negotiations with the legislature.
16 However, as everyone knows, the
17 state budget is having its
18 difficulties and these are
19 difficulties that are going to
20 affect all of us and already have in
21 some ways.

22 Some of you may know that the
23 City of New York has done some cuts
24 or is planning some cuts. A number

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1 local county services, county EMS
2 services, and this is only about a
3 third of what is actually spent by
4 the counties. But in some cases,
5 it's significant funding. So that,
6 at the moment, is on the table for
7 being cut, but I know that's also
8 being negotiated.

9 But those are the kinds of
10 things that all of you need to pay
11 attention to, to look at and to
12 think about how it might affect your
13 own locality.

14 In follow-up to that, I'd like
15 to bring to your attention hospitals
16 that have been affected by both the
17 economy, by the difficulty in
18 surviving financially in this
19 healthcare system.

20 Two hospitals in New York City
21 have filed for bankruptcy and are
22 closing. In fact, they formally
23 closed the 9-1-1 receiving
24 facilities in their hospitals this

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1 weekend. That is, St. John's and
2 Mary Immaculate hospitals in Queens.

3 Mary Immaculate was one of the
4 trauma centers in Queens. They now
5 have closed. They do have some
6 limited services that are open just
7 to man the ED for walk-ins, but they
8 are no longer accepting ambulance
9 transports and have divested
10 themselves of their patients and are
11 moving their services out. By the
12 end of this month, they will be
13 fully closed.

14 There was conversation and
15 attempts to see if there were
16 buyers, people that would come in
17 and take these failing institutions
18 -- failing financial institutions.
19 That hasn't occurred. That may
20 occur in the future after the
21 bankruptcy court is finished.

22 But the difficulty in the
23 system is that these were two
24 community hospitals that served the

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1 to stay awake to. You know, how
2 healthy is your immediate system?
3 How healthy is your hospital system?
4 Are there any crises looming or are
5 there going to be such, because they
6 happen fairly quickly?

7 Although these two hospitals
8 were in difficulty for a couple of
9 years now, we were only formally
10 notified that they could not pull
11 out of their financial distress
12 about five weeks ago. And in a
13 space of five weeks, two hospitals
14 were closed. You have to think
15 about that in your community if that
16 were to happen.

17 Another hospital that has
18 indicated they will be closing is A.
19 E. Lee Memorial in -- I believe it's
20 Oswego County. Oswego, right? And
21 they will be closing, I believe, in
22 June and they'll be making plans to
23 do that. And they are making plans
24 to do that.

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1 same borough, you know, the borough
2 of Queens. And so to lose two
3 fair-sized community hospitals at
4 the same time has been an impact.
5 We have been working with the
6 hospital for quite a while now, but
7 certainly intensively for the last
8 month to monitor the situation.

9 Over the weekend, my staff
10 were visiting the two closed
11 hospitals, as well as four of the
12 most immediate impacted hospitals,
13 to determine how the shift in
14 patient load and 9-1-1 calls was
15 affecting the other hospitals. And
16 certainly, it was affecting them.
17 And we'll continue to work with the
18 EMS system over the next month in
19 monitoring the changes.

20 But I think this is something
21 that we all have to pay attention
22 to, but you as physicians and
23 leaders in your -- both in your
24 hospitals and your EMS system need

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1 DR. HENRY: That's in
2 Fulton?

3 MR. WRONSKI: Yes.

4 DR. HENRY: Oswego county.

5 MR. WRONSKI: Yes, Oswego
6 county. And they were identified in
7 the Berger Commission different than
8 the two Queens hospitals, which were
9 purely financial consideration.
10 They couldn't survive.

11 A E. Lee was identified as a
12 hospital that needed to close. But that,
13 too, is something that you need to think
14 about in your community. How does it
15 affect the overall response? How are
16 these patients picked up? Can the EMS
17 community deal with the new transports?
18 And that has to be evaluated by that
19 system.

20 So again, I just ask you, as physicians,
21 to stay in tune with what's going on in
22 your particular community and how your
23 hospitals are affected and how they may
24 be changed.

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1 The -- there is a lot of information and
2 -- yes, Dr. Cooper?

3 DR. COOPER: Mr. Wronski,
4 it may be almost presumptuous of me
5 to raise this issue, but the current
6 economic climate clearly does not
7 bode well for hospital services in
8 New York State. And I suspect that
9 with the closure of the two
10 hospitals in Queens and an
11 additional hospital in Oswego
12 county, we may be seeing the tip of
13 the iceberg.

14 We all know that hospitals in
15 New York State are running on a very
16 narrow margin versus those
17 nationwide and that if this current
18 economic climate continues, that we
19 may be seeing more hospitals in this
20 -- in this situation.

21 The Department, as we know,
22 requires that hospitals that are
23 forced to close present plans to the
24 Department as to how they're going

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1 that may be a bit of a stretch, but
2 our current commissioner has, on the
3 record, indicated on numerous
4 occasions his deep concern about the
5 potential limitation of access to
6 emergency services.

7 And I think there is probably
8 no body or no entity in state
9 government that's in a better
10 position to assist the commissioner
11 in answering those types of
12 questions than this one, and would
13 ask the chair to speak with you and
14 others in the Department, perhaps at
15 another time and place, to see what,
16 if anything, the SEMAC might be able
17 to add to these -- these discussions
18 in terms of optimally protecting the
19 public's health.

20 MR. WRONSKI: I appreciate
21 that offer. It would -- it would --
22 typically, there is a separation
23 between an advisory body and the
24 actual operations of an immediate

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1 to deal with the patients that they
2 formally serve, how those
3 communities will be affected and so
4 on. But to my knowledge, the SEMAC
5 has never been asked for its -- its
6 opinion regarding potential impact
7 on access to emergency services in a
8 particular region. I don't know if
9 there is a mechanism to do that, but
10 as we know, the artificial barrier
11 created between article 28 and
12 article 30 under public health law
13 is not a barrier that's respected by
14 patients who seek emergency services
15 outside the hospital and that care
16 continues in the hospital.

17 And perhaps, at least as the
18 Department thinks about its
19 responsibilities to the public, as
20 it always does, that if future
21 hospital closings are anticipated,
22 perhaps the advice of the SEMAC
23 might be sought in terms of access
24 to emergency services. I realize

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1 emergency and individual situations.
2 So I don't know how the SEMAC would
3 fit into that, but certainly the
4 SEMAC is not dissuaded by me or
5 anyone from thinking about these
6 situations, offering its assistance.
7 I will certainly make that known to
8 the Department.

9 But you might, at some point,
10 consider as a group, you know,
11 looking at the situation and
12 particularly as it progresses and as
13 we've seen certain hospitals
14 shutting their doors, the State
15 Trauma Advisory Committee is looking
16 at the issue. They actually have a
17 small group together that, I
18 believe, will look at the reasons
19 and causes of recent closures around
20 the state in the last few years and
21 how does that -- is there anything
22 we can learn from that to prevent,
23 you know, future issues or what kind
24 of solutions might we have to make

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1 recommendations.

2 And certainly the SEMAC could
3 do things like that, as well. It
4 has a role in the statute now that
5 advises the department on hospital
6 -- certain hospital issues.

7 So there can be a role for it.
8 Whether there's one in these last
9 minute types of situation, probably
10 not for a variety of different
11 reasons, but I will make the offer
12 and let them know that the SEMAC is
13 open to advice if the Department
14 feels it needs to reach out for
15 that.

16 I wanted to make mention,
17 again, of the air medical crisis
18 that we're seeing in the country.
19 There is a national body that's
20 meeting to discuss the issues of air
21 medicine and the tragedies that have
22 occurred over the years in air
23 medicine across the country. And I
24 think we need to stay in touch with

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1 Health.

2 There is a small group that
3 oversees all of the board issues,
4 not just this one, but a hundred
5 separate advisory boards that report
6 to the commissioner. I think a
7 little over forty of them are
8 statutory. And so there are certain
9 general guidance policies that the
10 Department has put together on how
11 boards should operate, what rules,
12 what funding, etcetera, etcetera.

13 And it gets so complex and
14 some of the rules of change that
15 they decided to have a full-day
16 meeting with members of the
17 different bureaus and divisions who
18 have advisory boards. And so myself
19 and some of my staff attended one of
20 these full-day sessions.

21 One of the things -- and there
22 were many things that come out of
23 it. One of the things that came out
24 of it that I'm going to bring to

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1 that, listen for their reports,
2 react to them, see how they apply to
3 New York State and not forget the
4 New York State issues. I think
5 we're one of the more proactive
6 states. We've done a lot in terms
7 of meeting with our air med
8 professionals and the SEMAC and the
9 state council have had their
10 membership run a committee over the
11 years on this.

12 But I think the national
13 attention now deserves that we pay
14 attention to it and see what
15 recommendations that body will
16 ultimately come out with. So I just
17 wanted to put that out there for you
18 not to forget.

19 The -- online medical control.
20 It was very interesting discussions,
21 but I wanted to bring up something
22 that occurred at a full-day meeting
23 I had with the board for the
24 councils in the Department of

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1 your attention and we're going to
2 have to work on. Dr. Dailey knows
3 about it, because he was at the
4 State Trauma Advisory Committee.
5 And I think Dr. Cooper was there
6 when I had that discussion.

7 First, I'll tell you that I
8 don't have an absolute understanding
9 of this issue, as I don't have an
10 absolute understanding of most, but
11 one part of this came out pretty
12 clear.

13 When there are policy
14 discussions by a policymaking
15 advisory body such as this one or
16 the State EMS Council, when they are
17 done out of this room and out of the
18 public venue - okay - we have to not
19 discuss and make decisions on policy
20 offline. What we can do is work on
21 a product, work on carrying out a
22 policy vote - all right - put
23 together documents that are carrying
24 out a policy vote. But the

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1 decision, for instance, on whether
2 or not medical control, online
3 medical control, should only be
4 directly to a physician or it could
5 include some other level of provider
6 is a policy discussion that has to
7 happen here or at another public
8 venue that this group is holding and
9 that we have advertised and make
10 available to the public. Otherwise,
11 the offline conversations are
12 considered inappropriate.

13 This comes out of, apparently,
14 a couple court cases -- I don't know
15 if they were New York State cases or
16 not -- in which board members of a
17 particular board -- I don't know
18 which one it was and it wasn't
19 mentioned, actually -- had
20 discussions about a policy that was
21 going to come up for a vote and they
22 were discussing it wherever, in some
23 hallway, at some dinner meeting,
24 wherever it was. And it was an

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1 discussions that were going on by
2 e-mail, which I thought were very
3 rich and useful for people that have
4 time to discuss this issue. And I
5 was told that, in fact, in the
6 future, those kinds of discussion
7 have to happen here.

8 Now, once you decide that
9 here's our policy, here's what we
10 believe, then you can put together a
11 group of people who go out and write
12 the policy details that are going to
13 support this. But the general
14 policy that online medical control
15 will only be a physician or will be
16 a physician who is providing
17 direction to the following levels of
18 providers under the following
19 context. You know, some general
20 policy vote is made. Once you do
21 that -- that has to happen here.
22 The rest of the details, again,
23 could be done in another context.

24 So it was clear to me and I

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1 innocent discussion. It was a
2 discussion about what do you think
3 and they discussed it. That came up
4 at the court. The court threw out
5 the board's decision saying that
6 decisions had been made outside of
7 the public venue and were
8 inappropriate, that policymaking
9 boards are supposed to have their
10 discussions on policy within the
11 public meeting itself.

12 So this caused pause for a
13 number of us, but particularly me
14 because we do a lot of work and you
15 do a lot of work and a lot of it's
16 done by e-mail, some of it off-site
17 meetings. So what's the line? What
18 is the interpretation? And I met a
19 second time with counsel on this.
20 And by the way, this isn't one
21 lawyer's opinion. This comes out of
22 counsel's office. It was reviewed
23 by general counsel, as well.

24 And I used the medical control

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1 stated this to the lawyer that we'll
2 be talking a lot because we're going
3 have to learn where the lines are.
4 There's a little bit of a gray area
5 here.

6 But the medical control
7 conversations were a good example
8 for this lawyer to review, and she
9 said that I don't see anything
10 nefarious about the conversation.
11 It was open. It was on a general
12 e-mail account for everybody, but it
13 was everybody on the board but not
14 everybody, necessarily, was there
15 and certainly the public wasn't
16 there. And those conversations need
17 to happen here.

18 So in the future, when we do
19 one of these discussion, we'll have
20 to have them here first and then
21 move the details and the committee
22 work following the general policy
23 decision. So, any questions? Yes,
24 Dr. Cooper.

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1 DR. COOPER: Mr. Wronski,
2 I think all of us have had a little
3 bit more time to think about this
4 since last week when this was first
5 brought to the attention of the
6 State Trauma Advisory Committee.

7 There is no deliberative body
8 in the world that does not do a good
9 deal, if not a great deal, of
10 preparatory work prior to the actual
11 sit-down and hash-out meeting, which
12 we all agree should be conducted on
13 the public record. And any
14 decisions that are made need to be
15 conducted on the public record after
16 a full and fair and free debate with
17 an appropriate quorum present and
18 all SAPA regulations followed to the
19 letter.

20 But at the same time, the
21 virtual shutting down of preparatory
22 work that allows those discussions
23 to take place in a fruitful manner
24 and allows the members of the

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1 and free debate has been the -- has
2 been the mark of this particular
3 committee for a very long time and
4 decisions have really never been
5 made outside this room because
6 that's the nature of how we
7 function. But it would be, I think,
8 really stifling to the -- to our
9 business and would really hamper our
10 ability to protect the public's
11 health if our discussions were
12 limited to the very short amount of
13 time we actually have to sit
14 face-to-face around this table.

15 MR. WRONSKI: The
16 preparatory work is okay, and I
17 wasn't told it couldn't be. You can
18 do research. You can get facts and
19 prepare a report for the committee
20 to review. What the key was that --
21 is that there couldn't be
22 discussions pro and con between
23 voting delegates prior to the public
24 meeting about what do these facts

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1 policymaking board to make informed
2 decisions with all the information
3 before them is going to be seriously
4 hampered by this -- by this set of
5 decisions if incorrectly
6 interpreted.

7 I, personally, would suggest
8 that we need a -- we need a fairly
9 definitive statement from counsel as
10 to whether discussions that take
11 place that, in effect, are merely
12 discussions and don't reflect any
13 sense that decisions are being made
14 outside the - you know - the rooms
15 where the sunshine is present,
16 whether such discussions are really
17 inappropriate, because that's really
18 the fundamental issue. The issue is
19 are the decisions being made outside
20 the room where the public can't see
21 them or are they being made around
22 this table.

23 I don't need to really
24 reiterate for anyone here that full

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1 mean, what do they suggest, which
2 way do they sway me, what do you
3 think. Let me know when you have
4 those kind of conversations online
5 outside of the meetings.

6 For instance, the
7 sub-committee meeting today is
8 perfectly acceptable. It's a public
9 meeting and it's broadcast -- not
10 broadcast on the web, but it's
11 available. People can come in and
12 listen.

13 Again, it was these offline,
14 out of earshot discussions between
15 voting members and how much can you
16 or can you not do. And like I said,
17 there is a gray area and we're going
18 to learn more of what that is. I'll
19 keep having conversations. I'll
20 bring back your concerns to counsel.
21 Maybe we'll even have counsel here
22 to answer questions.

23 But they were pretty
24 definitive, you know, the offline

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1 discussions that lead to policy,
2 that include policy discussions and
3 what way you -- whether you support
4 or not or that you influence another
5 member in supporting or not
6 supporting your opinion can't happen
7 outside of the public venue. And
8 that's what the court said and threw
9 out some board's opinion.

10 But it doesn't mean you can't
11 have conversations, but they are
12 going have to be limited to
13 non-policy, you know, debate. It's
14 going to have to be more of a
15 factual kind of discussion.

16 But we'll try to hash this out
17 as time goes on and it is going --
18 it may well be necessary for me to
19 have a lawyer here at one of the
20 meetings to discuss this.

21 DR. FAIRBANKS: Can you
22 clarify whether this impacts our
23 REMACs? Do the REMACs fit the
24 definition of a policy-setting

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1 and members of the DOH over lunch,
2 as being potentially problematic.

3 On the other hand, you're
4 highlighting that they may indeed
5 violate law. If we have to restrict
6 our conversation on these things,
7 the business of this group will
8 stop. We might as well just cease
9 operation and allow this just to
10 move on. I just don't understand
11 from what you're giving us here how
12 we can conduct business.

13 MR. WRONSKI: Okay. Well,
14 it's clear to me -- what -- I'll ask
15 counsel, one, to draft a little bit
16 more of a guideline, a written
17 guideline on this. And two, to --
18 to ask if counsel can attend one of
19 the meetings and have a discussion
20 about this.

21 DR. HENRY: Okay. Did you
22 have anything else?

23 MR. WRONSKI: The -- no, I
24 think that was it. Thank you.

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1 organization?

2 MR. WRONSKI: I didn't ask
3 that question. If you want me to
4 ask it, I can.

5 DR. FAIRBANKS: Good
6 point.

7 MR. WRONSKI: And I won't
8 give an opinion, as I'm not a
9 lawyer, on that. I have an opinion.
10 I'll just hold it. Thank you.

11 DR. DAILEY: As I said at
12 the STAC, Mr. Wronski, I've gotten
13 asked for some additional
14 clarification to this.

15 I sign out to Dr. Funk on a
16 pretty regular basis when we're
17 working together, and invariably the
18 discussion changes -- turns from how
19 our kids are doing, ultimately to
20 issues involving medical care, very
21 frequently things that are of
22 discussion here. I don't foresee
23 the academic discourse that we have,
24 or that I have with Dr. Fairbanks

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1 DR. HUFFNER: We won't be
2 talking about this outside this
3 room, of course.

4 DR. HENRY: Okay. Thank
5 you.

6 DR. MCEVOY: Could I ask
7 about one rumor?

8 DR. HENRY: Rumor? Okay.
9 Is that unfinished business or is
10 that EMS?

11 DR. MCEVOY: Well, it's for
12 the director. I seen a couple of
13 e-mails that the Atropine pens may
14 be resupplied near their expiration,
15 which I believe is April. Is that
16 -- can you confirm or deny that?

17 MR. WRONSKI: That there's
18 a resupply? We've been advised that
19 there is an approval to purchase a
20 resupply. It won't be a hundred
21 percent resupply. All right? We'll
22 have to be -- we'll have to decide
23 how to put it out there, either in
24 lesser quantities or to the higher

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1 risk areas.
2 But the answer is we were
3 advised that there was money
4 available and they were going to
5 purchase a resupply for us and it
6 would happen this year. I don't
7 have the dates, because I wasn't
8 given any at this point, but they
9 tell us that that would happen.
10 DR. MCEVOY: Okay. Thank
11 you.

12 DR. HENRY: Any other
13 questions for Mr. Wronski? Okay.
14 Unfinished business. Dr. Dailey,
15 you had a report?

16 DR. DAILEY: Sorry. This
17 is just going to take a minute.
18 Standby.

19 So, I had promised to come
20 back to you after a year and talk to
21 you about how Fentanyl was going
22 from a REMO perspective. I wanted
23 to take a minute and highlight both
24 a little bit of where pain

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1 to allow paramedics to exercise
2 their medical judgment when taking
3 care of patients who are having
4 painful conditions.

5 Forty-two states, therefore,
6 allowing standing order of
7 medication. This was thirty-five.
8 And twenty-eight states,
9 interestingly, allow the standing
10 order use of Fentanyl for pain
11 management. There are twenty-nine
12 states in the country that allow the
13 use of Fentanyl prehospital.

14 There were a few
15 inconsistencies in the research.
16 However, most of those have been
17 answered.

18 This is what the map looks
19 like right now. You'll see several
20 states, including New Jersey and
21 Rhode Island as two of our
22 neighbors, that are slightly blue.
23 That's because they are considering
24 moving to standing order management

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1 management is across the country, as
2 well as how the program has worked
3 in the REMO region.

4 I think it's important when we
5 do something new that we bring it
6 here for academic discourse and
7 certainly not have any of those
8 discussions behind closed doors.

9 Quickly, just national trends.
10 First of all, at this point, there
11 are only eight states that have a
12 requirement for physician contact
13 prior to giving narcotic analgesia.
14 There actually were some errors in
15 this data. This was data reported
16 to us on a survey of state EMS
17 directors. There actually were
18 three EMS directors that got the
19 information from their state
20 incorrect, and this was passed on to
21 me at the national association of
22 EMS physicians.

23 There were fifteen states in
24 2004, so the trend, very clearly, is

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1 -- sorry, standing order protocols
2 for analgesic administration. And
3 otherwise, it's the white states
4 that are the ones that remain as
5 physician contact required. All of
6 the blue states, the dark blue
7 states, do not necessarily allow
8 Fentanyl on standing orders for
9 every type of pain and they don't
10 necessarily allow it for all of the
11 services. Some states, for example,
12 California, has a pilot project in
13 one county. Also, notably from
14 this, there is no political
15 statement being made by the choices
16 of colors.

17 Just to highlight where we've
18 gone, in 2005 we started our
19 partnership with narcotics
20 enforcement and the bureau in order
21 to improve pain management in the
22 region. We did that in no small
23 part with grant assistance from
24 prehospital trauma life support

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1 foundation and the National
2 Association of EMTs and I certainly
3 want to thank them for that support.

4 In 2006, we were the first
5 region to do standing orders for
6 Morphine. Happily, I see more and
7 more regions doing that. Our
8 research has certainly indicated
9 that that is both appropriate and
10 safe and that our providers are very
11 conservative with their use of pain
12 management.

13 In 2007, we demonstrated --
14 our research here showed a twenty
15 percent decrease in time to
16 medication, which is very impressive
17 and we liked a lot. I'm very
18 impressed by the improvement in
19 documentation by our paramedics and
20 our critical care techs.

21 And in 2008, as you know, we
22 were the first region to use
23 Fentanyl.

24 We reviewed 34,593 ALS calls

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1 administrations grossly. We
2 collected that data just recently.
3 We then went through and looked to
4 see how many cases where we used the
5 two hundred micrograms were allowed
6 under the state policy and the
7 patient was still in severe pain.
8 That, actually, was twenty-two
9 cases, which is almost ten percent.
10 These were for some patient that
11 were at the farther reaches of our
12 region and would have benefited from
13 a larger dose available or a larger
14 quantity available in a controlled
15 substance plan.

16 Mean time to medication. This
17 was at one agency. Mean time to
18 medication was about twenty minutes.
19 The standard deviation, though, is
20 pretty large at thirteen minutes.
21 It's important to recognize Fentanyl
22 is, indeed, only given on physician
23 orders. One agency actually
24 reported that it took less time to

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1 that took place in REMO in 2008. In
2 the course of that time, we
3 administered Morphine 2,037 times.
4 During that time, we have a time to
5 medication of about seventeen
6 minutes. There is some discrepancy
7 in this. We were only able to look
8 at this in a few of our agencies and
9 very clearly, the seventeen minute
10 time to medication was only in
11 agencies where there were two
12 paramedics available or two advanced
13 providers so that it looks like
14 somebody was getting intravenous
15 access and somebody was getting
16 medication.

17 When there was a single ALS
18 provider, it took about five minutes
19 longer in order to get the
20 medication.

21 Fentanyl, in that same time
22 period, about less than ten percent
23 of the amount of time that we used
24 Morphine we used Fentanyl. 276

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1 get Fentanyl into a critical
2 patient, a trauma patient requiring
3 physician orders, than it did to get
4 standing order Morphine in the
5 patients, because they were on the
6 phone with the physician earlier in
7 the course of care because the
8 patient was so sick. I thought that
9 was very interesting.

10 But we did not have any
11 reports through this of conflicts
12 between providers and physicians.
13 So the mean time to medication
14 reported by one agency was fifteen
15 minutes and another agency it was
16 twenty, so in keeping with the
17 amount of time it took to get
18 Morphine on board.

19 Interestingly, over the last
20 six months, we've seen an increase
21 in intranasal administration of
22 Fentanyl to children. This is using
23 a mucosal atomizer device. It's
24 extremely well validated through

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1 research done mostly in Australia
2 and has really shown good results,
3 very good results, for our kids in
4 acute pain. The kids will be scared
5 of a needle almost as much as they
6 are of that broken arm they're
7 screaming from. We give them a
8 little squirt of Fentanyl in their
9 nose at one to two mics per kilo and
10 then they don't mind when we later
11 start an IV. It has worked
12 extremely well for our kids.

13 Briefly, how it was used.
14 Sedation several times for painful
15 procedures, like removing from --
16 people being removed from cars that
17 they were entrapped in. Abdominal
18 pain a lot. A lot of uses for
19 abdominal pain. Multi-trauma and
20 lower extremity pain, interestingly,
21 coming next. But it's being used
22 significantly. Interestingly, it's
23 being used, in some cases, for the
24 initial medication because the

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1 ampule and then you've got glass in
2 your hands. There are things to
3 break ampules, but that's -- again,
4 you're trying to fix something
5 that's a bad idea.

6 The other thing -- okay.
7 First, ampules. And then the other
8 thing, if you draw up the entire
9 syringe full of drug, you then have
10 a hundred micrograms of drugs in a
11 syringe. There's the potential for
12 giving too much medication to your
13 patient. If you draw from a vial,
14 you can draw it exactly as much --
15 exactly the amount you need to give.
16 You then have a sealed vial that you
17 can then carry with the rest of the
18 drug in it. So for a prehospital
19 environment, it's a much safer way
20 of carrying the drug.

21 Were there any problems as a
22 result of the medication? There
23 were concerns about over sedation.
24 There were concerns about

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1 providers are subscribing quite well
2 to the literature that shows that
3 Fentanyl does have a more rapid
4 onset of action and they're dosing
5 it more appropriately for patients'
6 level of pain. And then, Morphine,
7 secondarily, for its longer effect.
8 And that's been working very
9 successfully. Again, that's all
10 being done with medical
11 consultation.

12 A couple of problems. One
13 phone call that actually woke me up
14 this morning was the breakage of an
15 ampule. All of the problems that
16 we've had with this medication has
17 been the result of what the
18 medication is being carried in.

19 The medication is currently,
20 according to DOH policy, being
21 carried in ampules. Ampules are
22 dangerous to providers because
23 there's the potential for a provider
24 to get injured when they open that

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1 respiratory depression. There were
2 concerns about rigid chest. No,
3 there were absolutely no problems as
4 a result of the medications. This
5 has worked very well for our
6 patients.

7 Brief comments, and these came
8 from the surveys we put out to the
9 ALS coordinators of the agencies
10 that are currently using Fentanyl.

11 "Why can't we report on
12 Fentanyl like our other narcotics?"
13 My answer back to them was that the
14 Department of Health was concerned
15 about Fentanyl and we'd like to make
16 sure that it's being looked at
17 quarterly rather than every six
18 months. But they did ask that the
19 paperwork reflects the exact same
20 pathways.

21 They'd like to carry more
22 Fentanyl, because they recognize in
23 some of their patients, they need
24 more because they're coming from a

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1 greater distance. My suggestion
2 would be to review our policy
3 statement and see if we could
4 actually raise that so that the
5 local Department of Health reps can
6 work with the agencies to modify
7 their controlled substance plans to
8 carry as much as may be needed by
9 their patients. Likely, that in
10 some cases, would be four hundred
11 micrograms.

12 Ampules. I'm going to ask no
13 other things in bold letters but to
14 say please, please, please, the
15 ampules have got to go. It's just a
16 bad idea to step backwards and use
17 ampules.

18 The idea was that ampules
19 cannot be diverted. You can't take
20 the drug out of them. Well, that's
21 not true. If we -- we can try
22 anything we want to keep somebody
23 from diverting a drug. We need to
24 try the things that will be as

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1 hundred mics per controlled
2 substance in a unit, all right, on
3 an agency by agency basis, and
4 modify those reports so they are
5 consistent with other narcotics.

6 I would also like to change
7 the date of the yearly report. This
8 is an administrative oversight in
9 the reporting structure, but on that
10 -- on the Fentanyl policy, it
11 requires that the medical director
12 report to the state by 12/31 of each
13 calendar year the usage for that
14 year. It's physically impossible
15 for a report to be written before
16 the quarter is closed, so perhaps if
17 we could change that date to
18 January, it would be much, much
19 better and wouldn't put everybody in
20 violation right away.

21 And the next is to consider
22 doing this reporting regionally,
23 building and then using a regional
24 narcotics report plan that would

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1 reasonable as possible and take the
2 steps that we can. But ampules are
3 not the answer because of the
4 problems they're causing. We need
5 to look past this.

6 And one other person who said
7 -- and this is for fairness. There
8 was one person that said the ampules
9 weren't a big deal. That was also
10 an agency that hadn't used the drug.
11 "I will never use Fentanyl again
12 because of the ampule." This was
13 much more common.

14 Our regional request, first,
15 please, let's modify the policy. We
16 need to allow vials. Perhaps vials
17 inside shrink wrap if there is
18 concern for diversion from the vials
19 themselves. And we can pursue some
20 different ideas and work on them
21 with the bureau, but this is for
22 safety of administration and
23 actually safety of the medication
24 itself. Allowing more than two

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1 actually be more standardized across
2 the agencies, making it a little bit
3 easier for the agencies to recognize
4 the best way to do this and then
5 doing it, actually, through the
6 local Department of Health reps so
7 that they have a good sense of
8 what's going on with the agencies
9 themselves.

10 So, nothing further. A brief
11 report on an extremely successful
12 program. Thank you very much.

13 DR. HENRY: Thank you.
14 Any questions?

15 DR. HUFFNER: Just one.
16 Was there any diversion that you
17 found, Dr. Bailey?

18 DR. BAILEY: No, no
19 diversions.

20 MR. DELAGI: That call
21 total, the 34,593, was that your
22 total ALS calls in the region for
23 the --

24 DR. DAILEY: Total ALS

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1 calls in the region for the year.
2 MR. DELAGI: Thank you.
3 DR. HENRY: Any other
4 questions or discussion? Dr.
5 Fairbanks.
6 DR. FAIRBANKS: I just
7 want to point out. I don't think
8 there's much to improve this,
9 dramatically improve the care of our
10 citizens more than this effort, and
11 I think Dr. Dailey deserves a lot of
12 credit for that, because a lot of
13 regions have followed that,
14 including ours, and I know that our
15 citizens are getting much better
16 pain treatment. So thank you.
17 DR. DAILEY: Thank you,
18 Dr. Fairbanks.
19 MR. YOUNG: I just want to
20 bring up one issue with the
21 multi-dose vials. The Department is
22 extremely focused on those, as you
23 know, with all the infection control
24 issues we had and we've actually

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1 we'll take a motion to adjourn.
2 DR. HUFFNER: So moved.
3 DR. DAILEY: I think the
4 Heart Association wanted to say
5 something.
6 DR. HENRY: Oh, did they?
7 So new business. Do you want to
8 introduce them?
9 DR. DAILEY: This is
10 Michelle Lieberman from the Heart
11 Association who just wanted to make
12 a brief announcement.
13 MS. LIEBERMAN: Yes, and
14 get put on the spot --
15 DR. HENRY: Could you go
16 to the microphone, please?
17 MS. LIEBERMAN: My
18 colleague with me today, Laurie
19 Young, is the State Health Alliance
20 director and she's officed here out
21 of Albany and I'm from emergency
22 cardiovascular care. And we just
23 learned, that came out in a media
24 advisory, that our latest

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1 talked about eliminating the
2 utilization --
3 DR. DAILEY: Let me stop
4 you right where you are, Greg. I'm
5 not in any way suggesting that we
6 use multi-dose vials. I'm
7 suggesting that we use vials,
8 hundred microgram vials.
9 MR. YOUNG: Unit dose
10 vials then?
11 DR. DAILEY: Yes, unit
12 dose vials. No multi-dose vials.
13 This is about patient safety.
14 Thanks.
15 DR. HENRY: Any other
16 questions or discussion? Thank you,
17 Dr. Dailey.
18 Any other unfinished business
19 people want to bring forward? All
20 right.
21 Is there any new business to
22 bring forward? Okay.
23 Our next meeting is June 9,
24 2009. And if there is nothing else,

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1 initiative, organizationally wide,
2 which many of you, I'm sure, have
3 heard of, Mission Lifeline.
4 And we're happy that REMO was
5 our first system in New York State
6 that entered into the database for
7 Mission Lifeline. And we wanted to
8 recognize and thank REMO for
9 stepping out and there's many other
10 systems now that are in process.
11 But this initiative, you know,
12 like so many that you hear today,
13 it's all about the community, it's
14 all about good patient care and
15 Mission Lifeline was all about
16 identifying the gaps in STEMI
17 patients and systems of care and
18 where can we improve systems.
19 And I am happy to say, from
20 the American Heart Association, EMS
21 is recognized in this initiative and
22 EMS is a strong part of the link of
23 the chain of survival and now you
24 have the organization of the

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1 American Heart Association pushing
2 for EMS and identifying the gaps.

3 Most of you are familiar with
4 the EMS surveys that just recently
5 came out, identifying twelve leads.
6 Where they are? Where they are not?
7 Where are the gaps? Where are the
8 systems? Where are PCI centers?
9 Where do we not have PCI centers?
10 Where do we have some issues like in
11 Queens, New York where we have
12 community partner centers that are
13 closing? That could identify other
14 gaps.

15 So we are working together
16 with EMS, with in-hospital,
17 out-of-hospital, with everybody,
18 moving forward for the patient, for
19 the community, in Mission Lifeline.

20 And I am very happy to be here
21 today and recognize REMO for
22 stepping up. We met with them
23 initially and Dr. Dailey was a
24 champion of champions and said,

105

1 Dailey.

2 DR. MCEVOY: For the
3 record, none of those meetings were
4 behind closed doors.

5 DR. HENRY: Any other new
6 items? Okay. We'll take that
7 motion to adjourn. All in favor?

8 SPEAKERS: Aye.

9 DR. HENRY: Okay. We're
10 adjourned. Thank you.

11 (Whereupon, the meeting
12 concluded at 3:13 p.m.)

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1 Yeah, what do we need to move this
2 forward and what does this do?

3 Now, Mission Lifeline, there
4 is a national database which you can
5 see symptoms from all over the
6 country. There are already
7 incidence databases and we can do
8 comparative analysis and find out
9 where good patient outcomes are
10 coming through our studies from that
11 point forward and do comparisons to
12 see. There are other communities
13 throughout this country that are
14 just like whatever area we are all
15 from.

16 So this is great. And again,
17 I want to say thank you and a little
18 spontaneous here, but I am so
19 grateful that we have champions and
20 hopefully many of you are following
21 the leader on the path working with
22 Laurie Young to also become part of
23 the Mission Lifeline.

24 Thank you. And thank you, Dr.

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108

1 C E R T I F I C A T E.

2

3 I, Nora B. Lamica, a Shorthand
4 Reporter and Notary Public in and for the
5 State of New York, do hereby certify that
6 the foregoing record taken by me is a
7 true and accurate transcript of the same,
8 to the best of my ability and belief.

9

10

11

Nora B. Lamica

13

14

15 DATE: February 19, 2009