

NEW YORK STATE EMERGENCY MEDICAL ADVISORY COMMITTEE
(SEMAC)

May 28, 2008
1:50 p.m.
Best Western Sovereign Hotel
1228 Western Avenue
Albany, New York

APPEARANCES:

- Dr. Michael Dailey
- Dr. Marshall
- Dr. Billittier
- Dr. Timothy Haydock
- Dr. Mark Henry
- Dr. Daniel Olsson
- Dr. Craig Van Roekens
- Dr. Joseph Takats
- Dr. Davidoff
- Dr. Cooley
- Dr. Roland
- Ms. Sharon Chiumento
- Dr. John Hasset
- Dr. Michael McEvoy

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DR. HENRY: Okay, if you could take a seat, and we'll call this meeting of the SEMAC to order. So, would you take a – if you can take a roll call, please.

(Roll call was taken.)

DR. HENRY: All right, thank you. I'd like the members who are not yet vetted to please sit at the table. There are name tags for you, too.

All right, so at this point we don't have a quorum to conduct official business. We'll conduct business, but we don't have a – by our by-laws, we have to have a majority of the members present that constitutes a quorum, voting members, so – we can conduct business. This can be a useful session, but I'm just announcing that to you.

And I think for opening remarks I want to say that I'm happy that people are here from regions that – they're not vetted. We've reached out to those regions. It's important to do so and have your presence at the table. And I want you at the table – and everyone knows that they can vote or not, but your opinions will be honored by us because you're

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1 representing your regions and the deliberations
2 of, you know, your REMACs and the other people
3 you represent. So we want you here. That's the
4 purpose of coming together.

5 I think it's probably important, because
6 we raise the vetted member issue many times
7 here, to just discuss that at this point, so we
8 can have an open discussion. And there are some
9 new business that has come to my attention and
10 Dr. Funk's attention since our last meeting on
11 that issue. So I'm going to ask Mr. Wronski at
12 this time if he would just discuss that.

13 MR. WRONSKI: Thank you. First, my
14 apologies to members who have waited a long
15 time; Dr. Davidoff comes to mind. He has called
16 me a number of times on his appointment, and
17 certainly we want you at the table. We
18 recognize your expertise, as well as others, who
19 have not been appointed to date and should be
20 here.

21 One of the things, though, in any public
22 body, and public policy body, is that it be
23 representative of the system at large, of the
24 population at large, and that's critical to
25 making good public policy. I have met on a

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couple of occasions, but on the last one with the Department's liaison to the Governor's office. And the Governor's office has indicated they have been reviewing councils, and they've looked at a variety of councils that the Bureau, in fact, oversees and assists in the administration. What has become very apparent, and that includes the State EMS Council, the SEMAC, the State Trauma Advisory Committee and the EMSC Council, is that we do not have a representative body that actually represents the diverse population that we have in the State of New York, and that was brought to my attention, and that issue needs to be resolved.

We have brought this issue up before at the Council probably about a year ago, and once before some years ago, about how do we work and get our EMS system to be more diverse, particularly in areas where there is large diversity. This issue right now, though, I have been advised by Department staff, through the Governor's office, that we will not be approving any vets. We will not be vetting any members at this time until such time as we resolve the issue. And the issue is not anyone's particular

1 fault. It is looking at yourself, how your
 2 council is established, both at the State level,
 3 at the regional level and locally at agencies.
 4 What's the system? Does it represent the needs
 5 of all of the people of the State of New York?
 6 And we need that appropriate representation.
 7 One of the things we're going to be
 8 doing is an evaluation internally. I'll be
 9 speaking to various associations. We'll be
 10 sending a letter to all of the regions for them
 11 to take a look at themselves and do
 12 self-evaluation. We've actually looked at some
 13 data just to understand the break-out of the
 14 diversity in the State of New York, and it is
 15 mixed, depending where you are in the State of
 16 New York. But there is a significant percentage
 17 of the population of the State of New York that
 18 represents a variety of people that we don't
 19 have representative on our councils. And it's
 20 felt that any council that sets public policy
 21 can't set good public policy unless it has some
 22 input of those diverse members of the
 23 population, and so we're going to look at that.
 24 If you're asking me, well, Ed, what is the exact
 25 numbers of the people we're talking about, I

1 director of the state EMS, about this issue and
 2 my responsibility as a state director. And my
 3 responsibility as a state director is not to get
 4 to a point where I have 91 separate State
 5 Council members – and that is the State EMS
 6 Council, the SEMAC, the State Trauma Advisory
 7 Committee and the EMSC Council, all right? And
 8 I have essentially one person who represents a
 9 diverse community, a diverse member of our
 10 society out of 90 some odd people. That's not
 11 appropriate, and it was really, you know,
 12 important for me also to realize that as a
 13 director. I think it's important for you to
 14 realize that in your own communities, in your
 15 own systems and evaluate that. And this doesn't
 16 mean that every community has a significant
 17 diverse membership, but many do across the
 18 State, Upstate and Downstate. And again, we'll
 19 be sending letters, asking you to do that
 20 self-evaluation, take a look at it and try to
 21 come up with recommendations. I will be
 22 personally calling a variety of associations
 23 regarding openings, getting people seated who
 24 can fulfill the necessity for diverse membership
 25 of our public policy committees. And I do want

1 have no exact numbers. It's not an exact-number
 2 issue; it's a representative number that is fair
 3 and reasonable, and we can be sure that when we
 4 set public policy we've heard from individuals
 5 who represent those diverse communities.

6 So my expectation is that we'll be doing
 7 this over the next, you know, three to four
 8 months, get this resolved before the next
 9 meeting, have members vetted and seated as soon
 10 as we can. In the interim, we will ask that any
 11 members who are not vetted, continue to
 12 participate in the SEMAC and in the State
 13 Council and discuss issues and move them along.
 14 We're going to continue, members who are vetted
 15 from the past, if you come to the meetings, will
 16 remain voting members. And again, those who are
 17 not vetted, we do ask you to come to the table
 18 and sit and participate. For those of you who
 19 can, we will pick up your cost to come to the
 20 table until such time as we have vetted members
 21 cleared, the non-vetted members cleared.

22 I realize it's a disappointment to many
 23 of you who have waited a long time, and I'm
 24 sorry about that. But I think if you sit back,
 25 and I had to sit back and think about this as a

1 you to know that it's not simply this committee,
 2 it's across the board we're taking a look at
 3 this. And it started, frankly, in the Spitzer
 4 administration where they began looking at it,
 5 and now Governor Paterson has continued that
 6 effort. And he said, Listen, before we vet, I
 7 want you to sit down; I want you to talk to your
 8 councils; I want you to look at this issue and
 9 see what you can do. And that's what I'm going
 10 to do. Are there any questions? And we'll try
 11 to give this the priority it deserves and move
 12 it along very quickly so that we can get our
 13 council's business together. I think we can
 14 conduct business. We can still bring in many
 15 vetted members who aren't here today. I believe
 16 there were five or six who were unable to come
 17 in. And make sure they understand it's
 18 important for them to be here. So, do you want
 19 to give other state reports?

20 DR. HENRY: All right. My reaction
 21 to this, when I talked with Dr. Funk and Ed, was
 22 to think immediately of efforts at the
 23 Association of American Medical Colleges, where
 24 I attend their meetings quarterly on their
 25 administrative body. And if you go to their

1 website, aamc.org, and put in "diversity," it
2 has been a part of a campaign, since I remember,
3 to try to make at least the physician members of
4 the medical profession reflect the population
5 and the arguments for that. And it's a rich
6 website, it's provocative, and it has, I think,
7 thoughts that are useful, as we think about our
8 role in this part of the health system, and
9 others may have similar contributions they can
10 make as we deliberate.

11 I want to just let you know that one of
12 our members who represents BLS, John Ashbauk,
13 unfortunately, for personal reasons, has
14 tendered a resignation from the SEMAC, so we'll
15 look to Dr. Funk for a replacement there, but I
16 just received that letter today and letting you
17 know.

18 Okay, we'll go to the minutes of the
19 last meeting. Are there any corrections or
20 additions, deletions? Hearing none, we'll take
21 a motion to accept them. Yes.

22 MR. HASSETT: There are just a
23 couple minor ones.

24 DR. HENRY: Thank you, John.

25 MR. HASSETT: On page number 8 –

1 on page number 8, there was a roll call vote,
2 and it was not indicated but the motion did
3 pass. It just indicated there was a roll call
4 vote, but there was no statement as to whether
5 it passed or not. The same thing occurred on
6 page number 10. Again, a roll call vote was
7 taken, and that motion did pass; although, it
8 was not recorded as passed.

9 DR. HENRY: Thank you.

10 MR. HASSETT: And again on 12.

11 MR. WRONSKI: All on motions?

12 MR. HASSETT: All on motions.

13 MS. CHIUMENTO: I also have a few.

14 There are several places, starting on page 13,
15 that core, C-O-R-E, should be course,
16 C-O-U-R-S-E. HIPAA is misspelled on page 18; it
17 should be H-I-P-P-A. Several places there is
18 Mr. Zastro; it just has "Astro." It doesn't
19 have a Z in front of it. And it says he's a
20 member of EMS; it should be EMS Bureau. And,
21 let's see, and then on page 64, SEVO should be
22 C-E-V-O instead of S-E-V-O.

23 DR. HENRY: Are there any others?

24 Okay, thank you. With those additions, is there
25 a motion to accept? Oh, we can't accept our

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1 minutes, can we? All right. We'll note that
2 for the record.

3 All right, at this point – John, are
4 you ready?

5 DR. FREESE: Sure.

6 DR. HENRY: I would like to welcome
7 Dr. Freese from the Fire Department of New York,
8 one of the medical directors. And we had talked
9 at previous meetings about hypothermia and its
10 use and helping survivors of cardiac arrest.
11 And Dr. Freese has prepared to give us some
12 information about the program being considered
13 in New York City. And it has been – two other
14 parts of the State have also been talking about
15 this, John, so we welcome your – the timeliness
16 of your talk here today.

17 DR. FREESE: (Inaudible.)

18 DR. HENRY: We'll let you know.
19 See how you're doing.

20 DR. FREESE: All right. Start
21 getting cold.

22 DR. HENRY: Start getting cold,
23 yeah.

24 DR. FREESE: Good afternoon. Thank
25 you, everybody.

1 This is a request for an initial
2 approval of a pilot project that we would like
3 to undertake in New York. To start, I'm going
4 to give you a little bit of background data
5 about where we are at now and give you an idea
6 why we want to move in this direction. I think
7 you mentioned or at least – sorry.

8 DR. HENRY: Mike.

9 DR. FREESE: Mike. There are at
10 least two other regions who are also interested
11 in doing something similar either to our first
12 phase or second phase, which I'll describe
13 shortly, but we think this is for our region,
14 and potentially for the State, maybe the rest of
15 the country, for everybody certainly to
16 consider, a step in the right direction towards
17 regionalizing cardiac care for the
18 out-of-hospital cardiac arrest patient, which is
19 likely to be our best chance of improving
20 survival.

21 There was this time not long ago when we
22 all thought that this was how the world works.
23 If you can reduce your response time by a
24 minute, you'll increase survival by seven to
25 twelve percent, seven to ten percent depending

1 on the – (inaudible). The problem with this,
 2 as we all know, is we don't operate on that
 3 curve; we operate on this curve. And we saw
 4 this between the phase in Phoenix and New York,
 5 when we saw that response times were reduced
 6 from 9.6 minutes to 4.7 minutes did not result
 7 in a significant increase in survival. It was
 8 significant but it wasn't what you want – might
 9 expect by that seven to ten percent slant. So,
 10 most of us actually operate here. And I think
 11 that for any EMS system, when you take into
 12 account your EMS processing time, your travel
 13 time, your vertical response time, even if
 14 you're in a relatively flat city, the amount of
 15 time it takes to get to a cardiac-arrest patient
 16 for most EMS systems cannot be less than four to
 17 five minutes, which means we're stuck with this
 18 flat portion of the curve. Changing things by
 19 30 seconds is not going to give you a great
 20 increase in survival. But what you can do is
 21 you can change the curve, and that's what we've
 22 tried to do in New York. So by shifting the
 23 entire curve up, you don't have to affect
 24 response times at all and you still impact
 25 survival. Much like every other region in the

1 on training, did it actually make a difference?
 2 Here's what we found. This is based on data
 3 that just terminated at the end of last month,
 4 which means we have short-term survival but we
 5 don't have long-term yet, so these patients are
 6 still in the hospital. What you can see at the
 7 bottom is if the number one predictor of a
 8 patient's ability to walk out of the hospital
 9 alive is our ability to achieve ROSC in the
 10 prehospital setting, we've increased that by
 11 almost 70 percent; from 20 percent during the
 12 Phoenix study up to 33.9 percent today. And I
 13 think that's fairly impressive for any system in
 14 the face of a 10 percent increase in overall
 15 system demand and equal, not a second change, in
 16 our cardiac arrest response interval, and a
 17 nearly 10 percent decrease in the number of
 18 patients presenting in v-fib. We have more
 19 in-planted defibrillators. We have patients who
 20 are on better maintenance therapy at home. Our
 21 ability to see VF isn't declining. We've seen
 22 that across the years in New York and every
 23 other place in the country that's looked, but
 24 for us we don't think we should stop there.
 25 So, that brings us to hypothermia. This

1 State and other parts of the country, we've been
 2 trying to figure out what exactly it is that our
 3 region needs to improve cardiac survival at the
 4 local level. For us, it has been a number of
 5 things that are listed out here. And without
 6 going through each one in detail, the goal of
 7 these was overall, in the past three years, to
 8 increase the focus on BLS cardiac arrest, and in
 9 particular those last two points, right before
 10 this March CPR trial which we presented about a
 11 year and a half ago here, those last two pieces
 12 where we've actually even gone to the point,
 13 thanks to a couple of our chiefs who have been
 14 very progressive in this arena, of actually
 15 sending EMS officers to every cardiac arrest.
 16 They're not there to intubate. They're not
 17 there to bring advanced drugs. They're not
 18 there to bring hypothermia. They're there to
 19 oversee CPR, to make sure that there is a
 20 rotation every two minutes, to make sure that
 21 people are adequately compressing the chest,
 22 that they are not hyperventilating, et cetera,
 23 et cetera.

24 The question is, well, after all of
 25 those hundreds of hours and a lot of money spent

1 was out of the European Resuscitation Council a
 2 couple of years ago. And what they said is that
 3 for unconscious adult patients, for hospitals
 4 operating under the European standard, the
 5 standard of care there was for patients to be
 6 cooled to 32 to 34 degrees following
 7 out-of-hospital VF arrest. I'll explain to you
 8 in a minute and show you the data as to why they
 9 say VF may in fact be extended now. But this
 10 has been the standard of care there for quite
 11 some time. In some parts of Europe, the entire
 12 country is regionalized so that patients are
 13 always brought to hypothermia centers. Many of
 14 you have see presentations by some of our
 15 colleagues from – (inaudible) innovative ways
 16 of performing hypothermia, including one patient
 17 who was packed in french fries from the local
 18 grocery store when they were transported to the
 19 hospital. That patient survived.

20 It's not a new concept. In the 1800s
 21 the Russians started doing this. The one
 22 problem was they packed a body and they forgot
 23 about the head. And since this is all about
 24 cardiac cerebral resuscitation, the goal has to
 25 be the head.

1 In the 1950's, Dr. Safar, one of the
 2 eminent researchers in cardiac-arrest research,
 3 looked and said "Hypothermia should be part of
 4 the standard of care, part of a community
 5 response to out-of-hospital cardiac arrest."
 6 The only downside to his initial proposal was
 7 that the target therapy was a little bit too
 8 aggressive. They were cooling below 32 degrees
 9 at which point the risk of coagulopathy, the
 10 risk of arrhythmias, refractory defibrillations
 11 following the initial arrest, those things all
 12 started to creep in because the temperature was
 13 a little too cool. But when they went back and
 14 looked at their initial animal models and said,
 15 What is it that made patients (dogs) survive?
 16 what they found is that being a little too cool
 17 at the beginning of the arrest, or having a
 18 lower temperature after the arrest, actually
 19 increased survival, and that kind of prompted
 20 more interest in this.

21 At the cellular level, at the tissue
 22 level and the organ level, we know a fair deal
 23 about the impact of hypothermia, and there are
 24 very few downsides to it. Overall, your
 25 metabolic demand is decreased probably early on

1 in the arrest, or in the post-arrest phase. No
 2 matter what your rhythm is – I'll show you in a
 3 minute – instituting hypothermia and
 4 maintaining it for 12 to 24 hours following the
 5 arrest is likely to increase your survival to
 6 hospital discharge, all of the things being
 7 equal. And even though there may be some
 8 complications – bacteremias and pulmonary
 9 processes, et cetera – these risks are very low
 10 and don't pan out when you look. In fact, in
 11 all of the studies I'm going to show you, they
 12 found no difference in the incidence of adverse
 13 events between standard normal thermia and
 14 hypothermia protocols. And again, without going
 15 through all of the things that may cause some of
 16 us to think back to our physiology classes and
 17 potentially seize, there are a lot of things we
 18 know about this and the way it works. On a
 19 metabolic level, we can talk literally for the
 20 rest of the day about all of the things we know
 21 this does from a beneficial standpoint. But
 22 it's all of those things that complicate the
 23 post-resuscitation phase where this is actually
 24 a benefit. And all of those areas are actually
 25 addressed by hypothermia which makes it better

1 than any particular drug, better than any
 2 particular respiratory pattern in a ventilator
 3 setting because this addresses a large number of
 4 aspects of post-resuscitation, myocardial
 5 dysfunction and post-resuscitation cerebral
 6 dysfunction.

7 So, here's some of the clinical data.
 8 I'm going to go from earliest to latest and save
 9 the best two trials, quote, unquote, for last.
 10 So, as early as 1998 there were early
 11 comparisons. This was 13 patients treated under
 12 a hypothermia protocol versus 15 patients in a
 13 cohort, retrospective cohort, who had been
 14 treated with a normal thermia protocol. And
 15 what they found is a difference in survival.
 16 Now, they didn't calculate P values here. They
 17 did not calculate odd ratios or relative risk,
 18 which I'll show you later from some of the other
 19 studies, but they did show that that survival
 20 rate, or that survival increase actually carried
 21 out, even for neurologically complete recovery.
 22 So the CPC score of Class 1 or Class 2 –
 23 meaning, the patient was able to function on
 24 their own – they still found survival –

25 Up to 2002, this was a small, but

1 multi-center, randomized controlled trial with
 2 24 patients. They only took prehospital VF
 3 patients. I'm going to kind of show you why
 4 later, but why we may want to rethink that now.
 5 They found in every other study, no difference
 6 in the complication rates, that they found a 55
 7 percent, versus 39 percent, survival to hospital
 8 discharge, neurologically intact. We're not
 9 talking about patients who were in a persistent,
 10 vegetative state. We're talking about walking,
 11 functioning human beings who may be as
 12 functional as they were when they left. Even at
 13 six months that mortality benefit extends out.
 14 Fifty-five percent of patients who were treated
 15 with normal thermia had died by six months,
 16 versus only 41 percent of all of the patients
 17 who were treated with hypothermia.

18 Another study. We'll kind of start to
 19 move through these more quickly, but the
 20 advantage here was they calculated the number
 21 needed to treat for a fairly inexpensive
 22 therapy. We're talking about a therapy that can
 23 be maintained. The biggest cost, without
 24 question, is the nursing hours that go into it
 25 in the hospital. But as far as supplies,

1 there's a myriad of ways you can institute
 2 hypothermia, some of which are as cheap as a
 3 refrigerator and a bag of saline, a thermometer
 4 and some drugs for sedation, things that we have
 5 in the hospital, in the ED, in the ICU anyway,
 6 so there is no big increase in cost above that
 7 incalculable cost of nursing time. So their
 8 number needed to treat was between four and
 9 thirteen. These are numbers that, if you take
 10 the low end, are two times the benefit that was
 11 seen with TPA or stroke, when we said it should
 12 be the standard of care throughout the country.
 13 If you take the number needed to treat, 13, it's
 14 barely worse than TPA, where the number needed
 15 to treat was 9. And, yet, we've said there's no
 16 difference in adverse effects. TPA became a
 17 standard of care with a number needed to harm of
 18 11, and here we are talking about a number
 19 needed to harm that's much larger than that.
 20 I'm hoping just to say that this should probably
 21 be our standard, and we should push to start to
 22 accept this.

23 Another study. This was looking at
 24 again the CPC scores, or clinical performance
 25 scores, for those patients who were discharged.

1 were all cooled at 33 degrees within two hours,
 2 so fairly aggressive cooling measures, and they
 3 were only maintained for 12 hours. And what
 4 they found is 26 percent of patients in the
 5 standardized arm survived to discharge.
 6 Forty-nine percent survived among patients who
 7 had hypothermia. The only other significant
 8 difference between these two groups that you can
 9 find when you look at their breakdown table as
 10 far as the difference in treatment, whether a
 11 slightly larger number of patients in the
 12 standard arm received, quote, unquote, more
 13 aggressive therapy with early PCI, et cetera.

14 And then the last study, the HACA trial,
 15 the Hypothermia After Cardiac Arrest Study
 16 group, this trial found that among patients –
 17 now it says "favorable neurologic outcome," but
 18 it should actually have a caveat saying see
 19 below. That's favorable neurologic outcome at
 20 six months. So 39 percent of patients that have
 21 normal thermia versus 55 percent. You can see
 22 the P value there, the relative risk. This is
 23 clearly a benefit to patients. The question is
 24 how to implement it.

25 And here's their proof of what we've

1 And 55.8 percent were discharged with good
 2 neurologic outcomes after being treated with
 3 hypothermia versus almost half that when treated
 4 with the standard of therapy, all other things
 5 being the same, and the time of the target
 6 temperature was five hours. This isn't
 7 something that we have to – there's a whole
 8 other discussion we had about prehospital
 9 hypothermia, but this isn't something you have
 10 to implement within an hour. This is something
 11 you can extend your transport times a little bit
 12 to get the patient to a center that can perform
 13 hypothermia.

14 Another cohort study. Again, 55 percent
 15 discharged alive if you had hypothermia in
 16 place, 36 percent if you did not.

17 And kind of moving down, skip on to the
 18 final two cases, the final two studies. These
 19 were published side-by-side on February 21 of
 20 2002. And these two studies were quoted by a
 21 number of editorials afterward, a number of
 22 other studies, that have since said this should
 23 be the standard of care. So this was a
 24 randomized, controlled trial. Seventy-seven
 25 patients post v-fib, prehospital arrest, that

1 been trying to accomplish in all of our systems,
 2 shifting that curve upward. We've already done
 3 it by providing the new standards of care, and
 4 now we can shift that potentially even further
 5 just by providing therapeutic hypothermia, so
 6 that we end up with our initial curve and we
 7 throw on top of it hypothermia, we end up with
 8 even more dramatic survival, not having to worry
 9 about our response time, at least not having to
 10 increase it by another minute over what we do
 11 now.

12 So this is the proposal we bring forward
 13 as a pilot project for the New York City region;
 14 that is, that all out-of-hospital cardiac arrest
 15 within the New York City 911 system would
 16 achieve ROSC in the field prior to transport
 17 being initiated, would be transported to centers
 18 that have joined in a cooperative agreement with
 19 the fire department to participate as regional
 20 resuscitation centers. And part of the
 21 requirement for that would be that they would
 22 provide therapeutic hypothermia to all qualified
 23 patients. It's not all ROSC patients. I'll
 24 show you how it actually breaks out in a few
 25 minutes.

1 That protocol, if you can call it that,
 2 it wouldn't be written into our protocols, but
 3 the procedure for going about this would be the
 4 exact same thing that we have been doing in our
 5 system since October 13 of last year, which is
 6 for patients who have an ST segment elevation MI
 7 demonstrated on 12 lead, rather than having
 8 regional destinations that are designated
 9 because we are not ready for that yet, our
 10 providers are calling our online medical control
 11 center – our online medical control physicians
 12 are making a patient-by-patient determination as
 13 to whether or not transport to a PCI center is
 14 appropriate base on the 12 lead EKG, based on
 15 patients presenting symptoms and based on other
 16 qualifying or disqualifying factors for that
 17 patient. The procedure would be the same for
 18 this. These would not be designated centers;
 19 rather, these would be partnership agreements,
 20 and through our telemetry side, or our online
 21 medical control side, we would make individual
 22 decisions about where to take those patients who
 23 achieve ROSC in the prehospital setting.
 24 We started this a few months ago by
 25 meeting with all of the hospitals. After a lot

1 my putting pins in a dartboard, if you will.
 2 But if you map out our hospitals and then you
 3 add to them the blue, which are the hypothermia
 4 centers, you can see we have a fair distribution
 5 of hypothermia centers. And, most importantly
 6 for us in our transport times, our operational
 7 issues, if you will, we have a center at least
 8 in every borough, and we have a fair
 9 distribution among the others with the usual
 10 concentration of centers in Manhattan. So our
 11 response times would not be much different than
 12 STEMI. In fact, if we laid our PCI center map
 13 over top of this, you would see there is almost
 14 no difference in the distribution, just by pure
 15 coincidence.
 16 The process continues. We had initially
 17 written this up with a very optimistic and
 18 aggressive target date of July 1, 2008. That's
 19 not going to happen. So what we're doing now is
 20 continuing with what we've been doing all
 21 along – meeting with the centers and
 22 maintaining our initial approach, which is that,
 23 since we were given the go-ahead from the REMAC
 24 from the executive committee following a summary
 25 document that was sent around and now bringing

1 of internal discussion about should centers,
 2 based on other data that shows that maybe half
 3 of these patients require PCI at some point
 4 following their arrest, should these centers
 5 only be designated PCI centers? Should these
 6 centers be everywhere? What we've decided
 7 initially is the data is not there to support
 8 anything other than an inclusive approach,
 9 whereby any hospital that can meet the
 10 criteria – providing hypothermia within four
 11 hours, having an active ICU, of having the
 12 ability to CAP or transfer patients for CAP,
 13 like any hospital can do – those very simple
 14 things, if the hospital is interested, then they
 15 can participate. The only other requirement
 16 that we'll get to in a minute, as part of that
 17 agreement that still has to be worked out, is
 18 this process can't be intact if we don't have a
 19 way to quality assure it. If we don't have a
 20 way to look at this data and say that this is
 21 actually making a difference in survival.

22 So today we have had a couple of
 23 meetings. We have 24 centers that are actually
 24 interested when you map that out over New York
 25 City. And this is not an official map. This is

1 this to SEMAC for approval here, we will move
 2 forward with this pilot project once we have
 3 enough centers that we can look and say this
 4 will not operationally affect our system, and we
 5 won't be taking patients in, quote, a dangerous
 6 amount of time, which is yet to be determined.
 7 Other things we still have in play that
 8 we need to have before this can go live,
 9 including the IRB application, we have, as we do
 10 the SmartCPR, gone through the Department of
 11 Health in New York City. Their IRB is serving
 12 as our IRB of record because the fire department
 13 does not have the IRB. They currently have the
 14 application in hand, as they asked, since May 1.
 15 We actually expect a decision in the next two
 16 weeks. The last communication we had from them
 17 was actually that this would be expedited, so
 18 they have seen no issues with this, because, as
 19 we explained to them, although, we want to do
 20 this as research, we want to publish this, we
 21 want to be very up front about this, as was
 22 discussed this morning, even if we can't publish
 23 this, we'll still quality assure this. We'll
 24 still get the data. We'll still go forward with
 25 the project. We're just looking to publish up

1 front, to be very open and honest about that.
 2 The data acquisition we will do along
 3 with SmartCPR. Because these will actually
 4 overlap for the next year and a half, the data
 5 acquisition becomes fairly easy. And if anybody
 6 wants, I can go into how we do that.
 7 We still have to draft the letter of
 8 intent and the memorandum of understanding
 9 between the facilities so that we're all very
 10 clear about what the expectations are, that
 11 there are no false pretenses or false hopes.
 12 And then finally making sure online medical
 13 control is ready for this, which is the least of
 14 my concerns.
 15 This is so small that you can't read it,
 16 but this is our one-page DCI that each hospital,
 17 with our data collection instrument, each
 18 hospital would fill out. It includes 41 data
 19 points that would be put into our SmartCPR
 20 database which includes another 125 data points
 21 on every patient. And when you multiply that
 22 out times the number of patients – and I'll
 23 show you in a second – what we end up with in
 24 approximately a year is a hypothermia database
 25 that can answer questions that at present no

31

1 excluded if we maintain our current age
 2 limitation of 75 years and younger, which is
 3 based on the data that's out there so far. And
 4 we would expect that of those patients who would
 5 then be enrolled, 15.3 would present ventricular
 6 fibrillation or ventricular tachycardia. Which,
 7 at the bottom, you can see 923 patients enrolled
 8 and treated with therapeutic hypothermia per
 9 year, giving us 141 v-fib v-tach patients,
 10 nearly double the amount that's in any
 11 controlled study to date. And then we've
 12 extended it because we have questions,
 13 especially for us – Dr. Brazant, in his
 14 expertise in pulmonology, has questions about
 15 other etiologies, in particular pulmonary
 16 etiologies such as asthmatic arrest, pulmonary
 17 embolism – arrest. We're not excluding those,
 18 so this would give us another population.
 19 Approximately, 15 percent of our arrests within
 20 that 923 would be estimated to not be witnessed
 21 arrests, and we would up with 600 PEA asystole
 22 arrests, which, I remember now that I skipped
 23 over it, but if I were to make you all dizzy and
 24 scroll back a ways, one of the last trials
 25 before I got to the HACA trial by Stephen

1 other database may be able to answer simply
 2 because we'll have the numbers.
 3 So here's our estimates. We have, based
 4 on the past 12 months of cardiac arrest data for
 5 SmartCPR, we have about 7,500 cardiac arrests
 6 per year. Three percent will be automatically
 7 excluded from this protocol because they will
 8 not be candidates based on their traumatic
 9 mechanism, which leaves us with 7,200.
 10 Forty-three percent of those are pronounced in
 11 the field. Of those not pronounced in the
 12 field, 40.9 percent actually achieve ROSC;
 13 that's all comers – witnessed, unwitnessed,
 14 bystanders, CPR, or not, any respective or
 15 presenting rhythm – which gives us nearly 2000
 16 eligible patients.
 17 You can then look at our exclusion
 18 criteria that we've laid out as recommended for
 19 each hospital; although, there will be some
 20 leeway. Two point six percent beyond the
 21 traumatic etiologies will be excluded for
 22 etiologies. Those primarily are patients who
 23 had exsanguination or CBA or SIDS as their
 24 reason for arrest.
 25 Fifty-one point nine percent would be

32

1 Bernard is that they found in one study a P of
 2 .025 when you looked at non VF VT patients for
 3 the advantage of hypothermia towards survival.
 4 It's only one study to date. Other studies have
 5 not found that, but 600 PEA asystole patients,
 6 we can certainly tease out which patients it is
 7 applicable for, which patients it is not and
 8 help to define the standard of care.
 9 If you then ask the question, Well, what
 10 does this mean at the end? If you just take our
 11 v-fib patients, without reading off all the
 12 numbers that are there, what it means is that
 13 without changing anything other than our
 14 transport decision, which would be an individual
 15 decision through telemetry, we result in 14
 16 additional neurologically intact v-fib v-tach
 17 survivors per year. Now, that's not including
 18 the 600 PEA asystoles. If you take our 2.9
 19 percent current survival for those patients,
 20 extend out what has been found in that one study
 21 to date, that number doubles or triples. And
 22 what we could end up with, quite frankly, is
 23 nearly 100 neurologically-intact patients at the
 24 end of a year, assuming this is a
 25 straight-forward and clinical practice as it is

1 a randomized controlled trial, which we all know
 2 isn't the case. But even if it's half that,
 3 it's 50 patients by us doing nothing other than
 4 taking patients to centers that are willing to
 5 implement this, quote, unquote, new standard.
 6 I already talked about this fact. We
 7 can answer a bunch of other questions. The 41
 8 data points that we're getting from the
 9 hospitals include a number of metabolic
 10 markers – their metabolic panel, their CBC,
 11 their EEG results, their lactate – a number of
 12 other markers that can then be used to help them
 13 predict, if they do predict it, whether or not
 14 patients should be treated with hypothermia.
 15 With 600 patients, if we can eliminate 300 of
 16 those patients appropriately by allowing our
 17 data to designate markers of benefit versus no
 18 benefit, it's only going to help to increase the
 19 impact of this patient who can possibly benefit.
 20 There have even been discussions already of
 21 adding on to this other things which would not
 22 be a part of this – request today. With this
 23 kind of data set, you can also start to ask and
 24 answer questions under other grants and other
 25 projects, either within the hospitals or as

1 for another year and a half we project at this
 2 point.
 3 And then phase II, which we'll not
 4 discuss today in the interest of time and in the
 5 interest of it not being for another sixteen to
 6 eighteen months, but phase II we fully
 7 anticipate, and I know one other region already
 8 is looking to do the same, there is certainly
 9 data to suggest that prehospital intra-arrest –
 10 otherwise, known as preservative hypothermia –
 11 may actually provide further benefit. Of those
 12 18 metabolic impacts that hypothermia has,
 13 several of those, such as preservation of ATP
 14 scores, and reduction of hypoxic injury, and
 15 even simple things like the reduction of
 16 microvascular thrombi, those things all happen
 17 early in the post-arrest phase. In fact, some
 18 people would say that the ATP preservation needs
 19 to happen within the first 10 minutes following
 20 the arrest. Studies in Europe have looked at,
 21 well, can you achieve ROSC and then start
 22 hypothermia? What they found is that versus
 23 transporting to the hospital to initiate
 24 hypothermia, one study to date has actually not
 25 been published yet, but was stopped early

1 joint projects, as to whether there are other
 2 biomarkers. There's a neurologic – there are
 3 two neurologic markers to date that have been
 4 looked at. The numbers haven't been big enough
 5 to show that they're predictive, at least not
 6 for 48 hours, but it's questions like those that
 7 nobody has the numbers to look at that maybe we
 8 can answer by doing this.

9 So what we're looking for here today is
 10 a vote to move forward – although, I guess with
 11 no quorum, it may be a nod until further
 12 notice – to continue to move forward toward a
 13 protocol where we would transport patients, much
 14 like STEMI, with an online medical control
 15 physician after achieving out-of-hospital ROSC,
 16 irrespective of all other potential exclusions
 17 with the exception of traumatic etiology. For
 18 our region or for our providers, it would be no
 19 difference in what they do other than that
 20 transport decision. Their cardiac arrest
 21 resuscitation efforts would be identical to what
 22 they are today, and that means that it is
 23 universal throughout our system, including
 24 non-911 and 911 with the one exception of
 25 SmartCPR, and that will not be able to continue

1 because they found the difference or the delta
 2 between starting in the field after ROSC and
 3 starting in the hospital after transport,
 4 actually only gave them an eight-minute
 5 difference in the time it took to achieve a
 6 target temperature of 32 to 34 degrees. But
 7 there is data coming out to support intra-arrest
 8 hypothermia, in that, A, it will provide those
 9 benefits; B, because of the vaso-constrictive
 10 effect it may actually reduce your need for
 11 Epinephrine, Vasopressin, whichever your system
 12 of choice happens to be. And by doing that, you
 13 may reduce the post-resuscitation myocardial
 14 dysfunction that follows from Epinephrine or
 15 Vasopressin until one day maybe we'll have – or
 16 Epinephrine, but that's too far off.

17 So this will bring back, as a
 18 supporting – or as a second phase, hopefully
 19 bring that back this fall for discussion. We
 20 have prehospital protocols we've been developing
 21 for that, a description of our enrollment,
 22 whether it would be FDNY or whether it would be
 23 the entire 911 system. And even – we have
 24 already broached with our IRB, given our success
 25 with the waiver of informed consent, the

1 SmartCPR and have a blessing from the Department
2 of Health to pursue, through the IRB, another
3 waiver of informed consent, should we decide to
4 really pursue this as research in the second
5 phase and actually randomize that prehospital
6 hypothermia. Again, those decisions are all yet
7 to be made, but this is where we anticipate
8 going in the next few months to a year.

9 If anybody would like, I can give you
10 copies of all these little articles. I have
11 most of them in PDF files. So really, if
12 anybody wants any, I can hand these off as a PDF
13 file. With that, we'll accept any questions.

14 DR. HENRY: All right, thank you.
15 Questions? Comments?

16 DR. YOUNG: Just a quick question,
17 Dr. Freese. In phase I are you applying
18 hypothermia, or is that in phase II?

19 DR. FREESE: Phase I is hypothermia
20 in the hospital.

21 DR. YOUNG: In the hospital only.
22 So you transport to. And then phase II will be
23 in the field.

24 DR. FREESE: Phase II is in
25 the field.

1 DR. YOUNG: Thank you.

2 DR. FREESE: Phase I would be ED or
3 ICU depending on that particular facility. We
4 have no mandate from our standpoint. The only
5 requirement we have put forth is that we have a
6 target implementation of four hours post ROSC.

7 DR. HENRY: Michael.

8 DR. DAILEY: John, I think this
9 project sounds extremely exciting, and I'd love
10 to see success of it so we all know more
11 information. On the other hand, I have some
12 concerns about the amount of information you're
13 getting back from the hospitals themselves.
14 You're doing a STEMI trial now. How successful
15 is the fire department at getting good follow-up
16 information on the STEMI patients they're
17 transporting to these facilities?

18 DR. FREESE: That's a great
19 question. We're actually meeting with Greater
20 New York on June 9, and their membership has all
21 been invited. To date, we have had mixed
22 success. In all candor, the greatest success we
23 have had is from the cath labs themselves. In
24 fact, some of the cath lab directors are
25 incredibly good at getting us data and getting

1 that data to us in a regular fashion. The
2 following morning, they send the patients that
3 they have had. The biggest issue we have had to
4 date, I would say, is the emergency departments.
5 So as we were talking about actually yesterday,
6 we can capture most of the – those patients who
7 actually go to cath. It's the 50 to 75 percent
8 that don't go to cath that we currently have
9 issues with. And for many of those patients,
10 calling the cath lab, who has said all along and
11 have been very energetic about saying, sure,
12 we'll give you the data. It's no different than
13 data, in fact much more limited, than what
14 they're giving to the cardiac advisory group and
15 they're reporting to the State, et cetera. The
16 problem becomes those patients that never make
17 it to their radar, so those 50 to 75 percent who
18 end up in the emergency department, even though
19 we're having our online medical control
20 physicians and paramedics call back an hour to
21 two or three hours after the patient is
22 transported. And you can imagine. Think about
23 your own hospitals and your own EDs. The
24 patient comes in at 6:30 in the morning.
25 Somebody calls 95 minutes later at 8:05. The

1 staff has changed over, the nurses have changed
2 over, and that patient has gone to the floor.
3 Okay, going to the floor might be a dream to
4 some, but those patients are off the radar for
5 the providers who are there. So the EDs have
6 been the majority of the issue. From a work
7 standpoint, what we've said is that when we have
8 these centers that we've struck an agreement
9 with, part of the agreement would be that
10 someone is, in writing, responsible. And I
11 think for most of the hospitals we're talking
12 about – I'm not speaking for all of them. In
13 fact, I'm not speaking for any one in
14 particular, but there have been a number of ICU
15 directors, because this is where the majority of
16 the therapy will take place, and these are the
17 experts we'll be dealing with. They've been
18 very good at saying we'll take this on. Whether
19 it's their nurse subordinator or whether it's
20 their PA, somebody, a fellow, somebody will be
21 responsible. For them, it's not a great
22 workload. It's 1,900 patients, but for the
23 majority of those patients, as you saw, the data
24 says is limited to the top third of the page
25 which is some ED diagnosis, the reason for

1 exclusion from hypothermia. The rest of it
 2 remains blank. We're not gathering data on
 3 those. So for most hospitals, when you
 4 translate those numbers out, it actually becomes
 5 one patient every three to four days that each
 6 center – if all 24 participate, that each
 7 center would have to give us that limited data
 8 set on. The expanded data set would be
 9 approximately one patient every nine to ten
 10 days. And because we're doing this in
 11 conjunction with SmartCPR, we actually have our
 12 SmartCPR researchers who could call that day,
 13 follow up, and they can have contact, so it's an
 14 ideal time for us to try and get the data.
 15 MR. WRONSKI: I might add something
 16 to answer your question, Dr. Dailey. The
 17 Department's going to participate also in a
 18 meeting at Greater New York Hospital. We spoke
 19 to Dr. Brazant down in the city yesterday, and
 20 it's on this issue, the sharing of data, how
 21 that would happen. And we think some of those
 22 issues are going to be resolved at the meeting,
 23 you know, because the Department's very
 24 interested, in that if the system is functional,
 25 it would be very beneficial to everybody to have

1 that would come into play. If there were a way
 2 to standardize the prehospital CPR and to do it
 3 repeatedly, and we put in place measures, but
 4 they're subjective measures. If we had an
 5 objective way of doing that, certainly that
 6 would be something we would want to incorporate,
 7 but at this point I don't think we have enough
 8 data to support it. Some of the drugs that are
 9 out there even, the use of steroids in the
 10 post-resuscitation setting, the use of
 11 anti-coagulants in that setting, I think all
 12 those things have promise that they're starting
 13 to show the literature – a degree of support
 14 for us to say this has to be a mandated part of
 15 your in-hospital therapy as well.

16 DR. VAN ROEKENS: Just a follow-up.
 17 Are you getting any support from any of the
 18 makers of the cooling devices?

19 DR. FREESE: For this particular
 20 project, to date, we have no additional funding
 21 beyond our own internal funding and what
 22 is going on through our SmartCPR. We have tried
 23 to work, and are working with greater New York.
 24 Dr. Isaacs, of our office, is working with
 25 Greater New York to set up a meeting where all

1 the data shared and studied.

2 DR. HENRY: Craig.

3 DR. VAN ROEKENS: I think this is a
 4 great idea. The history of resuscitation has
 5 got a lot of anecdotal sort of background to it,
 6 and my concern is that we've looked at different
 7 ways to decrease metabolic rate – there was
 8 recently an article in the New England Journal
 9 about that. Are you looking at all and any
 10 other pharmacologic agents, and is there going
 11 to be any kind of reporting on that as well that
 12 actually is somewhat easier to achieve?

13 DR. FREESE: We've actually offered
 14 the participating or interested, I should say,
 15 interested centers, we've have offered them a
 16 number of protocols derived from our own
 17 facilities that are currently instituting
 18 hypothermia as well as others throughout the
 19 country and even some in Europe – given some of
 20 the partnerships that some of our colleagues
 21 have. So we've offered them a number of
 22 protocols. There will be no standardization
 23 beyond the hypothermia. If there's convincing
 24 data to support an additional or even
 25 synergistic therapy that comes about, certainly

1 of the vendors will be invited so that they can
 2 show their wares and demonstrate what they have
 3 and distribute their literature. From our
 4 standpoint, we have said all along, how they
 5 accomplish hypothermia is entirely up to the
 6 hospital. So for us, there is no interest in
 7 any particular vendor. In fact, for phase II,
 8 we haven't even decided what vendor we're going
 9 to use ourselves.

10 MR. FAETH: Don Faeth. I applaud
 11 this initiative. I think it's great. It's
 12 exciting. I'm looking forward to seeing what
 13 the results are, but in the beginning of the
 14 presentation you stated that there was a
 15 decrease in response times, and everybody was a
 16 little surprised that there wasn't a
 17 significant, appreciable change in cardiac
 18 arrest survivability. And I think part of the
 19 problem there is that the foundation of that is
 20 floored. The fire department is still measuring
 21 response time, from the time that a unit is
 22 dispatched to the time that they arrive in front
 23 of the location, not to the bedside of the
 24 patient, and that's a problem. If we lived in a
 25 community where we were responding to one-family

1 homes, it would be negligible. You would have
 2 to have a 30-second hit, but New York City is a
 3 vertical city, and I can tell you from
 4 experience it can take an additional three to
 5 four minutes, sometimes more, to get to the
 6 bedside of that patient, which is going to
 7 totally skew the results, because the response
 8 is that initial patient that you think is
 9 viable, because you had formidable response
 10 time, actually is not viable because they have
 11 been down for eight minutes. And that, I think,
 12 is something that needs to be considered and
 13 looked into. I know other systems in the
 14 country have adopted measuring their response
 15 times from the time of dispatch to the time of
 16 the bedside, and they have significantly
 17 improved cardiac viability by doing so because
 18 they've allocated resources to address that, you
 19 know. And then if you also tack on the time it
 20 takes to even dispatch the unit, you add even
 21 more time. So it's just something to look at.
 22 DR. FREESE: I think it's a great
 23 point. We actually had some meetings last week
 24 for SmartCPR, and we were discussing this, our
 25 system versus London's and some others, that

1 trying to, in the post-arrest phase, standardize
 2 care through SmartCPR, by not treating rhythms
 3 but by rather treating individual patient
 4 physiology, I think those things try to overcome
 5 for us, and for a lot of other systems at issue,
 6 what really is response time. And hopefully we
 7 cannot so much focus on a curve, as we move
 8 forward in all of these things, but rather
 9 realize that the individual patient is no
 10 different than the patient that comes in with an
 11 infection in the hospital. We don't in our
 12 practice give patients an antibiotic, the same
 13 antibiotic for every infection. We treat their
 14 physiology. We treat their disease, their
 15 severity of disease, their co-morbidities. We
 16 adjust our therapy to what the patient's
 17 condition is rather than what the patient's ICD
 18 code is, or ICD-9 code is. So I think by moving
 19 resuscitation in that same direction
 20 hopefully – it's a huge barrier to overcome.
 21 DR. HENRY: Dr. McEvoy.
 22 DR. MCEVOY: In this proposal
 23 you're going to include the PEA patients with
 24 the v-fib patients. In your ROSC data now, do
 25 you separate those groups?

1 have actually considered participating, and I
 2 think it's a universal problem. That issue of
 3 response time is so variable. Some places it's
 4 the amount of time EMS handles the call. It's
 5 from the time the unit is assigned until the
 6 time the unit arrives at the address, which is
 7 different than the time the call is received;
 8 that interval is always going to be variable.
 9 For us, the PD process of time is always there.
 10 So I think there are a lot of issues. I think
 11 one of the things that this and SmartCPR tried
 12 to address is the fact that, particularly in New
 13 York, because of our vertical response time,
 14 which we just looked at and published, is 2.3
 15 minutes, on average, for some patients. With
 16 that kind of information, the thing that we
 17 really need to do, in my opinion alone, is that
 18 we have to eventually move to the point that we
 19 stop treating cardiac arrest like it's
 20 universal. As you just said, the patient who's
 21 considered "viable," quote, unquote, because it
 22 took us three minutes to drive from the
 23 ambulance station with our cross – the address,
 24 may or may not be variable, or may or may not be
 25 viable. But the things we're doing now by

1 DR. FREESE: In the ROSC data that
 2 I showed you, no. We are still reviewing some
 3 ROSC data, which I can give you preliminary
 4 results from, but these are not finalized. When
 5 you break down our ROSC improval (sic), as my
 6 memory serves, which is going to be quicker than
 7 me trying to pull it out, when you break it down
 8 our overall ROSC went from 18 percent to 23
 9 percent – all comers, all arrests, all rhythms,
 10 all ages, not excluding any etiology including
 11 traumatic, which we had excluded for that slide
 12 I showed you. So, if you take all of those, our
 13 ROSC can jump from 18 to 23 percent. If you
 14 break that down, what's really exciting about
 15 this, I think, is what proves what we've all
 16 thought in these resuscitation changes, our PEA
 17 asystole ROSC rate has increased from twelve and
 18 a half to eighteen and a half percent, and our
 19 VF VT ROSC has increased from 26 percent to 55
 20 percent.
 21 DR. MCEVOY: Do you intend to break
 22 them out in this study, though?
 23 DR. FREESE: Absolutely.
 24 DR. MCEVOY: I guess, the thing
 25 about the PEA people, it's very limited data.

1 DR. FREESE: The IRB application
 2 includes currently fourteen different intended
 3 subgroup analyses, including biorhythm,
 4 including by age.
 5 DR. HENRY: Okay, well, it was very
 6 interesting. Any other questions or comments?
 7 So the REMACs have been involved in this
 8 locally? Does the REMAC have any questions or
 9 comments on this? Let me put it another way.
 10 Is there any way that you think this group can
 11 be helpful to you other than, you know, give and
 12 advise, and questions, and inquiries? Specific
 13 questions you have or specific questions the
 14 REMAC would have for us? That's what I would
 15 like to clarify.
 16 DR. MARSHALL: I don't think New
 17 York City REMAC, you know, had the usual
 18 questions about transporting patients to a
 19 center that's being designating, and we follow
 20 the same process that we do with STEMI. Nobody
 21 really had any issues with that. There were
 22 some issues in regards to active cooling in the
 23 prehospital setting, as were discussed earlier
 24 today. So as we move along, there was a more
 25 aggressive timeline than there is now, so we

1 brought to the SEMAC's attention. REMAC's very
 2 involved in it in the City because it does
 3 require an ambulance to go to certain places,
 4 and they built that into the STEMI system, and
 5 they built them into the City. They did invite
 6 the Department down to their initial meeting
 7 which was – I was, you know, somewhat surprised
 8 how overwhelmingly positive every single
 9 hospital that was there wanted to do this thing.
 10 They were very positive about it. So it's a
 11 true community effort to make something happen.
 12 There's no – for the SEMAC, there is really no
 13 need to say we approve this, but basically we
 14 think it's important that you hear this, what's
 15 going on in a particular region. It does
 16 involve EMS. And in the future, when we talk
 17 about the potential of EMS personnel who might
 18 actually do cooling, then I think we have to get
 19 more actively involved in it; is that an issue
 20 that needs to be approved by the SEMAC as a
 21 protocol issue, as a standard of care practice?
 22 But that's down the road.
 23 DR. BILLITTIER: I guess I would
 24 agree, I think this is a great study. I thought
 25 this body had to approve prehospital studies,

1 have time to discuss some of the issues that had
 2 come up, but nothing specific.
 3 DR. HENRY: Okay, thank you. And
 4 from your perspective, Dr. Freese?
 5 DR. FREESE: No, I think that
 6 was – we just wanted to ensure that we were
 7 consistent with what we had done with the STEMIs
 8 to make sure that – or I should say our PCI
 9 transport process, to make sure that we were not
 10 either in advance or, I should say, premature on
 11 any issues of designation and that we weren't
 12 setting out trying to – the issue. We were
 13 just trying to make sure that we deliver
 14 patients in what has previously been an accepted
 15 fashion.
 16 DR. HENRY: All right, great.
 17 Thank you very much. Yes.
 18 DR. BILLITTIER: Can I ask, is
 19 there an approval needed for this body?
 20 DR. HENRY: No. That's what I was
 21 asking. To me, there doesn't seem to be one,
 22 but I don't know if there was a specific
 23 question, if there's a query in your mind.
 24 MR. WRONSKI: We're not looking at
 25 this stage for any specific approval, but it was

1 though. That's what led to my question. So
 2 regions can do prehospital studies with
 3 REMAC-only approval.
 4 MR. WRONSKI: Well, I don't see it
 5 as necessarily a prehospital study. It's one in
 6 which the hospitals are going to do the primary
 7 bulk of this. EMS is going to deliver patients
 8 to them, and that's certainly part of it, but
 9 it's not necessarily a, quote, unquote,
 10 prehospital study; although, it's being driven
 11 by FDNY EMS along with – remind me. Is the
 12 physician who was working, Dr. Brazant,
 13 initially from Columbia Pres or Mount Sinai?
 14 DR. FREESE: Yeah, as far as the
 15 study goes, even just the expert consulting, the
 16 group that's primarily focused on this is our
 17 office plus Dr. Stephen Meyer from Columbia.
 18 DR. HENRY: Okay, let's go to the
 19 staff report.
 20 MR. WRONSKI: A couple of other
 21 issues of import, a report on the state budget.
 22 At present, it's not a good picture. How it
 23 affects, given, you know, health care systems,
 24 will depend over time, but clearly from a
 25 picture of monies available to EMS, whether or

1 not there will be additional funding available,
 2 the answer right now is very unlikely. What we
 3 have been advised is probably for the next two
 4 to three years there will be a tightening of the
 5 belts. And we, just as every other bureau, are
 6 asked to come up with cuts, cost-saving
 7 initiatives. A number of staff vacancies across
 8 the Department, including a couple that the
 9 Bureau had been working on, are frozen, and we
 10 will have to make additional arguments. Only
 11 critical positions will be filled. And we've
 12 been told, you know, to look at a two to three
 13 percent overall cut, even if it has been
 14 approved already by the legislature and the
 15 Governor on the prior budget, and we have to
 16 self-evaluate and come up with ways to save
 17 dollars. And, you know, recommendations have
 18 been made by all bureau directors how we might
 19 do this, and me and Marjorie are continuing to
 20 evaluate some of this.

21 One of the things I do, I can tell you
 22 that is across the board, is we're, on a state
 23 level, looking at public meetings, how to hold
 24 them, other than in person, when possible, and
 25 cut down on the number of meetings. Next year

1 at this point we will probably go to quarterly
 2 meetings unless things change. That's one of
 3 the smaller measures that will occur. We'll
 4 still be able to get a lot of business done as
 5 long as we work efficiently and in between the
 6 meetings by teleconferences and such to get
 7 business done, but that's one of the areas we're
 8 looking at.

9 I'd like to report briefly on the EMS
 10 memorial and thank Dr. Funk, who represented the
 11 EMS community at the memorial, and Dr. John
 12 Morley, who represented the Commissioner, and
 13 Fire Administrator Madison, who spoke for the
 14 Fire Services from the Office of Fire Protection
 15 and Control. All of the talks that were
 16 delivered by the speakers, including the FDNY
 17 minister, were very well done. The memorial was
 18 very well appreciated by the families who were
 19 present, and they specifically talked to me
 20 later about that. They felt it was a very
 21 professional and touching memorial service, and
 22 they appreciated it for their family members.

23 The Blood Council, we had a special
 24 one-day meeting with Dr. Lyndon from the Office
 25 of Public Health and members of the Blood and

1 Tissue Council to discuss moving along the
 2 approval of EMS in the transport and maintenance
 3 of blood for patients, and I think it was a very
 4 positive meeting. Dr. Funk was there. Do you
 5 want to say anything – at that meeting or about
 6 the meeting?

7 DR. FUNK: I agree, it was a very
 8 positive meeting. It was amazing to get
 9 everybody that needed to be at the table at the
 10 table, and a lot of work got done during that
 11 day. We're at the point right now where we have
 12 a proposed curriculum. We have a proposed
 13 protocol and guideline. That committee is
 14 tossing it around electronically, and,
 15 hopefully, we can get the group together, at
 16 least by electronic means, to be able to bring
 17 something forward to this group through
 18 education and training, Med Standards, SEMAC and
 19 then Council, to finalize everything in
 20 September. That's what I would be hopeful for.
 21 I don't see anything, from my perspective,
 22 stopping that.

23 MR. WRONSKI: Right. One of the
 24 issues I also wanted to bring to your attention,
 25 and some of you know it but don't know all the

1 details, is that members, who have been around
 2 as long as I have here, remember the rollout of
 3 the Ryan White legislation for EMS and emergency
 4 services. Unbeknownst to the states – because
 5 I know from my fellow state directors that this
 6 caught them by surprise as well – is the
 7 provisions in the federal Ryan White Act that
 8 allowed EMS to get information regarding
 9 patients who they may have – HIV patients who
 10 they may have been exposed to, that provision
 11 for emergency services was dropped. It was
 12 dropped sometime late in 2006. We learned about
 13 it earlier this year and began inquiring as to
 14 why is it going to be put back in. There's the
 15 possibility, because there are some federal
 16 discussions going on about adding it back into
 17 federal legislation, but at this time what we've
 18 done for the last couple of months is we've met
 19 with public health representatives who also are
 20 going to be having, I believe in two weeks, a
 21 conference call with OFPC and the Department of
 22 Criminal Justice Services and their
 23 representatives regarding a letter which we're
 24 going to send out. There is state law which
 25 will allow for the continuation of the release

1 of this information. I'm going to have staff
 2 put together a short PowerPoint that will be
 3 shared with people. We'll put it on our website
 4 which will explain the law, but let me roll
 5 through the key pieces of it.
 6 Section 63.8m, small m, of Title 10 of
 7 New York Codes, Rules and Regulations is the
 8 state law that currently exists for the
 9 disclosure of HIV status of a patient which can
 10 be made to an emergency responder who may have
 11 been exposed. The regulations differ a little
 12 bit from the federal law, which has a designated
 13 officer. In this case under Part 63.8, small m,
 14 such disclosure may be made to the physician or
 15 other medical provider of the emergency
 16 responder. So you can advise your own
 17 physician, or your agency physician, or another
 18 medical provider, that you believe they – an
 19 exposure has occurred. An incident report
 20 documenting the details of the exposure,
 21 including witnesses to the incident, if any,
 22 should be on record at the agency with
 23 supervisory staff. A request for disclosure of
 24 HIV status is made to the patient's physician or
 25 to the medical provider designated by the

1 hospital where you brought the patient. This
 2 request can be made by the exposed person, so
 3 the emergency medical care provider who believes
 4 they were exposed could make that request
 5 directly as soon as they get to the hospital
 6 when they believe they had an exposure, or it
 7 can be made by his or her physician as soon as
 8 possible. The medical provider, or the EMS
 9 provider, or the medical provider designated by
 10 the hospital or clinic, reviews, investigates
 11 the claim of exposure; it certifies that the
 12 information is necessary for immediate
 13 decisions, initiating – regarding initiation or
 14 continuation of post-exposure, prophylactic
 15 treatment for the EMS provider. And, B, that
 16 the EMS provider status is either HIV negative
 17 or unknown, and that if the person's status is
 18 unknown, the EMS provider has consented to an
 19 HIV test. So if you don't know before the
 20 patient's status as to whether or not their HIV
 21 positive is released, yourself, as an EMS
 22 provider, need to have a test to confirm that
 23 you're not currently infected with HIV. If such
 24 test results become known as positive prior to
 25 the receipt of the patient's HIV status, no

1 further disclosure of the patient's HIV status
 2 may be made. Documentation of the request for
 3 this information is made in the medical record
 4 of the EMS provider. If the patient's
 5 physician, or the medical provider designated by
 6 a hospital, determines that a risk of
 7 transmission has occurred, then the patient's
 8 physician, or the medical provider designated by
 9 the hospital or clinic, may release the HIV
 10 status of the patient. There is also – and
 11 this is a may, if you're unsure about whether or
 12 not there was truly an exposure, you may go to
 13 the Public Health Office in your county and seek
 14 a consult with the municipal health commissioner
 15 or district health officer. Separate letters
 16 will go out to those people across the State so
 17 that they know this change has occurred.

18 So essentially, if we make it simple, if
 19 you believe there has been an exposure, you can
 20 either yourself at the hospital say I believe
 21 there has been an exposure and report that and
 22 request HIV status of the patient. At that
 23 point, though, you need to talk to your
 24 physician, or other medical provider who can
 25 represent you in evaluating the incident, along

1 with the hospital, and further request follow-up
 2 that that information be released. My thought
 3 is that many agencies, who already have a Ryan
 4 White type of system in place, could keep that
 5 in place if they choose to, but what they need
 6 to add is these other components to it. It
 7 doesn't mean that you have to dismantle
 8 everything, but you need to understand that that
 9 doesn't exist anymore in law and that the State
 10 regulation is in place, and has been in place
 11 for awhile, but people have, as I understand it,
 12 generally used federal regulation.

13 So, we'll be sending out a letter to all
 14 services, and there will be letters going out,
 15 we believe, from our sister agencies to police
 16 and fire who are not EMS specific agencies. And
 17 we will put together, in the next two weeks, a
 18 short PowerPoint. It just goes through these
 19 key elements. So that will be available and
 20 agencies can pull it down from the website. Any
 21 questions?

22 DR. HENRY: Dr. Dailey.

23 DR. DAILEY: Sorry. Just as a
 24 note, this body, as well as the STAC, has
 25 supported the idea of source patient testing in

1 the past. Currently, that is part of a
 2 Departmental bill regarding HIV testing,
 3 specifically around how that testing would
 4 occur. It's not being met favorably for all of
 5 the parts of that bill and all of the conference
 6 calls that I have been on. However, I would
 7 like to recognize that the Department very
 8 clearly included the source patient testing
 9 components that we had suggested. And in the
 10 rest of the legislative efforts, they're being
 11 brought forth by the firefighters, the troopers,
 12 the emergency nurses and emergency physicians.
 13 We all recognize the Department's efforts
 14 towards source patient testing. But all of this
 15 issue goes away if we are allowed to test
 16 sources.

17 DR. VAN ROEKENS: Without
 18 permission.

19 DR. DAILEY: Without additional
 20 written consent, exactly. If that testing could
 21 be done for the treatment of our providers, for
 22 the treatment of the health care workers, the
 23 treatment of the public safety professionals,
 24 this problem completely goes away, and the minor
 25 irritation of the changes in the Ryan White Act

1 just don't matter to the providers of New York
 2 State.

3 DR. FUNK: So the law that is in
 4 place currently does not allow for source
 5 patient testing without source patient
 6 permission; is that right?

7 MR. WRONSKI: Right.

8 DR. FUNK: And that's what we're
 9 looking to change, correct?

10 MR. WRONSKI: Right.

11 DR. YOUNG: There is an exception,
 12 isn't there, for the criminal justice cases,
 13 those who are incarcerated or have been involved
 14 in a crime, or is that just proposed
 15 legislation?

16 MR. WRONSKI: I don't have an
 17 answer. I don't know. When we talked to our
 18 public health people, they brought up this
 19 particular legislation as it exists, and I
 20 didn't recall seeing anything in there, but
 21 maybe Dr. Billittier knows.

22 DR. BILLITTIER: It's for those who
 23 have committed sex crimes. They can be forced
 24 to undergo testing, but that is for the victims
 25 of the sex crimes, not for the bystanders,

1 providers, if you will.

2 DR. DAILEY: And only after the
 3 accused has been arraigned.

4 DR. BILLITTIER: No, I think now
 5 it's pre-arraignment as well, I think. What is
 6 the bill now? Is this – because this law has
 7 existed on the books. Is this a change to this
 8 law or is the –

9 MR. WRONSKI: No, existing. It's
 10 Title 10, New York Codes, Rules and Regs, Part
 11 63.8, small m, of the Public Health Law.

12 MS. GEIGER: Dr. Dailey is
 13 referring to proposed –

14 MR. WRONSKI: Right, modify it.
 15 The last thing we discussed at Medical
 16 Standards was I had sought further clarification
 17 of the SEMAC role regarding Medical Standards
 18 versus protocol, and Council made it clear that
 19 SEMAC establishes the medical standards in the
 20 State of New York, and that REMACs must follow
 21 those standards in developing of their
 22 protocols. There was not a prohibition, though,
 23 for the SEMAC to develop a very prescriptive
 24 medical standard or to use a format that we're
 25 used to of a protocol, but it is a medical

1 standard, and it's statewide. Regions, in the
 2 development of their protocols, need to follow
 3 those standards. And if they believe that they
 4 need to modify them because of their own local
 5 conditions, then they need to bring that to the
 6 SEMAC. The SEMAC's role is, in all cases, to
 7 review regional protocols for consistency with
 8 state standards. So we had a long conversation
 9 in Medical Standards regarding, you know, how
 10 prescriptive we might want to be, that each time
 11 we look at a medical issue, and a standard that
 12 we wish to set, we need to think about how
 13 detailed we need to be or whether we need to be
 14 broader in our recommendations and let our
 15 regions have more flexibility in how they might
 16 actually write a protocol on a given medical
 17 standard. But that again is up to the body of
 18 the SEMAC as to how they wish to do that. All
 19 of you come from regions, so you need to think
 20 about how it affects you in regions and whether
 21 or not you're comfortable with how the SEMAC
 22 issues its medical standards.

23 We are, and I made a recommendation,
 24 that a small group of SEMAC might convene over
 25 the summer, and that I would request that

1 Council be part of that group to further discuss
 2 this issue and flush out any questions you may
 3 have, because there were still questions that
 4 came up at the Medical Standards meeting. So I
 5 believe we had decided we were going to do that.
 6 Any questions?
 7 DR. HENRY: Okay. Hearing none, I
 8 would like to move to the committee reports.
 9 And Dr. Marshall, would you start, please?
 10 DR. MARSHALL: Yes, thank you. I
 11 think there are actually five action items, so
 12 I'll mention those first, and then, since we
 13 don't have a quorum, we'll mention them again at
 14 the next meeting for approval. These are in no
 15 particular order.
 16 Medical Standards reviewed and approved
 17 the Western Regional REMAC protocols with the
 18 following stipulations: There's one area, one
 19 protocol which had to do with arrhythmias, and
 20 they had transcutaneous pacing before Atropine,
 21 and we recommended that they go directly to
 22 transcutaneous pacing before Atropine in
 23 high-level blocks, and that was agreed to.
 24 Western Regional also wanted to include
 25 active cooling for post-cardiac arrest patients

1 of Propofol versus RSI in the prehospital
 2 setting. They came to Medical Standards and to
 3 REMAC for approval to use Propofol for this
 4 study only. Propofol is not a currently
 5 approved medication for prehospital use in New
 6 York State. There was long discussion about the
 7 use of Propofol and whether it's a study or a
 8 demonstration project or research. The
 9 Committee did approve the use of Propofol in the
 10 Central New York study specifically for this
 11 study, and only for the agency involved in the
 12 study. And they're here, if anybody has any
 13 questions on that.
 14 DR. HENRY: Any questions or
 15 discussion? Sure, Dr. Davidoff.
 16 DR. DAVIDOFF: Thank you.
 17 Dr. Davidoff from Finger Lakes REMAC. I was
 18 just curious to know why they wanted to use
 19 Propofol. I believe in Central New York they're
 20 already using etomidate.
 21 DR. OLSSON: One of the agency
 22 medical directors, who has a background, a PhD
 23 in pharmacology, wanted to look at and/or use
 24 one drug to streamline the process for sedation
 25 and intubation, as opposed to multiple drugs

1 in the prehospital setting. We had a long
 2 discussion about curriculum and standards and
 3 that since active cooling by prehospital
 4 personnel is not currently in the curriculum,
 5 that that was withdrawn, and with the
 6 presentation we had just a little while ago from
 7 the fire department, that will be further
 8 discussed as we move forward.

9 Critical care level technicians will be
 10 taught CPAP, using the currently approved
 11 paramedic curriculum, that was approved
 12 previously by SEMAC, for use in another region.
 13 And we had discussion on approval of curriculum
 14 and training for different regions. As each
 15 region brings forward a similar change in the
 16 training, that we don't have to reapprove it
 17 each time. So if we approve CPAP for one
 18 region, then as long as the next region agrees
 19 to use the same training and curriculum, that
 20 that would move forward. And that was from the
 21 Western Region, and that was approved.

22 The second action item was from Central
 23 New York who was doing, or would like to do, an
 24 airway study that was distributed, that went to
 25 the IRB. The airway study is to look at the use

1 that require multiple dosing schedules,
 2 paradigms, that kind of thing. That was the
 3 impetus for that.

4 DR. DAVIDOFF: Okay, thank you.

5 DR. HENRY: Hearing that, if I
 6 were – in the protocol that was presented,
 7 there was a split based on blood pressure, on
 8 what drug was used, so there were really two
 9 drugs used.

10 DR. OLSSON: Correct, but there had
 11 to be a way of addressing the hypotension.

12 DR. MARSHALL: And there is a
 13 summary available of the protocol, if you would
 14 like to take a look at it. If you didn't get
 15 it, I have an extra copy.

16 The next protocol that was approved was
 17 New York City Fire Department has identified a
 18 need for having special medics trained as rescue
 19 medics in New York City. These proposed
 20 protocols would allow specifically trained
 21 paramedics to provide care in critical
 22 situations like building collapse, trapped
 23 individuals. Some of the procedures that are
 24 not in the New York State curriculum include
 25 foley catheterization was one of them that was

1 commented on, as well as use of some other
2 modalities. All of the treatment provided in
3 the protocols are within the New York State
4 current protocols and New York City REMAC
5 protocols. Along with that additional training,
6 the fire department has put together a
7 curriculum. That curriculum will be submitted
8 to the Training and Ed Committee for review, and
9 then the whole package will be brought back to
10 SEMAC for review and action at the next meeting.

11 DR. HENRY: So I don't know if
12 anyone would like to hear briefly from
13 Dr. Gonzalez, but I would ask him maybe if you
14 could just introduce the topic. Is this unique
15 to New York, the only one that exists here, or
16 do other parts of the State have similar search
17 and rescue units?

18 MR. GONZALEZ: I'm Dr. Gonzalez
19 from New York City Fire Department. To my
20 knowledge, this is unique to New York City.
21 There are no other protocols or other systems
22 that are using it outside of the federal system
23 of the Urban Search and Rescue, so they've been
24 really created in sort of a vacuum at this point
25 based on the federal system and –

1 DR. HENRY: But I think it's
2 different in that there could be prolonged
3 rescue extrication efforts, correct?

4 MR. GONZALEZ: Right, yes, I'm
5 sorry. But the issue really has to do with
6 large building collapses, crane collapses and
7 industrial accidents at construction sites. And
8 should there be any other major event in the
9 subways or closed environments, that we would
10 have the ability then to provide specially
11 trained medical corps paramedics, approximately
12 50 in the city, half of which that you saw are
13 trained and certified by the federal government,
14 to be able to operate alongside rescue and to
15 have the advanced training in the medical
16 components associated with confined space and
17 collapse medicine, and also at the same time to
18 be certified in hazardous materials, operations,
19 and confined space operations, level A
20 operations, and a few working under the direct
21 supervision of a physician from the Office of
22 Medical Affairs and the fire department.

23 DR. MARSHALL: Two other action
24 items actually resulted from a previous approval
25 of a motion at SEMAC and SEMSCO, I believe, at

1 the last meeting regarding the implementation of
2 wave form capnography for all patients – for
3 all non-arrest adult patients and all pediatric
4 patients in New York to have wave form
5 capnography once they're intubated and
6 continuously thereafter. There was some
7 confusion as to the wording of the motion, so
8 there was a lot of discussion on clarifying what
9 some of the interpretation was. The first one
10 was what constitutes intubation, and that was
11 interpreted to mean intubation includes all
12 advanced airway devices absent a bag valve mask.

13 SEMAC and SEMSCO Medical Standards
14 recommends further that removal of the terms
15 related to allowing extension in the motion that
16 was approved. The REMACs and REMSCOs were given
17 the authority to allow for extension of the
18 requirement for wave form capnography after
19 January 1, 2009 by agencies who have services
20 that presented a reasonable reason why they
21 couldn't have it. Medical Standards had
22 significant discussion on that issue, about how
23 much of an extension should there be, should
24 there be any extension at all. If there is an
25 extension, what specific hardships should be

1 accepted as a reason for the extension? And
2 after the final discussion, Medical Standards
3 recommends that SEMAC and SEMSCO revisit the
4 motion and remove the wording which allows for
5 extensions of the implementation of wave form
6 capnography in the prehospital setting for
7 non-arrest adult and all pediatric patients who
8 are being intubated based on our definition.

9 The other issue was, and it had to do
10 with the extension, if the agency got an
11 extension, if they're unable to meet the
12 requirement at the deadline, they would not be
13 able – they would not be allowed or able to
14 intubate out-of-hospital non-arrest adults or
15 pediatric patients, period. And that came from
16 Medical Standards to SEMAC and SEMSCO.

17 There was quite a bit of discussion on
18 those issues. So, any questions?

19 DR. MCEVOY: Yes. What was the
20 conclusion about getting the word out about
21 this?

22 DR. MARSHALL: That was a second
23 motion, which was to request that the
24 Department – let me read it, make it easier.
25 The Department of Health was to make public any

1 agency name that is not providing wave form
 2 capnography, to meet the deadline with regards
 3 to the wave form capnography requirement. And
 4 it was left up to the Department to figure out
 5 how best to do that if it's, you know, placing
 6 on their website, sending letters to appropriate
 7 agencies and regions.
 8 DR. HENRY: I think there are three
 9 points, and I think you raised this a little bit
 10 at the last meeting. So first we read the
 11 motion from, I think it was the December
 12 meeting, and we've made a note that that's
 13 public record. I think it was webcast then, so
 14 we tried to get information out.
 15 DR. MCEVOY: But it's still – I
 16 mean it's hard to tell a city council go watch
 17 the webcast.
 18 DR. HENRY: Well, they have
 19 representatives, hopefully, who attend the
 20 meetings and report back. I know you have a
 21 newsletter that reports on our events.
 22 DR. MCEVOY: Sometimes they don't
 23 take my newsletter seriously.
 24 DR. HENRY: Mr. Wronski said he
 25 would get a letter out to agencies or regions

1 provide a certain level of care that we've
 2 determined should be provided, then it's
 3 appropriate that the community that they serve
 4 understand that. We did that back for
 5 services – and I believe there were only maybe
 6 two – who could not guarantee an EMT on a call.
 7 And it was required by the statute, by the
 8 statute, that the community they serve be
 9 notified that they could not provide that level
 10 of care. Well, here's not every call, but this
 11 is a call where somebody is unable to breath and
 12 you're going to intubate and you can't provide
 13 what this body has already said, this body and
 14 the State EMS Council have said, is a piece of
 15 equipment to assure your airway is properly open
 16 and you're breathing. And if you can't do that,
 17 then your community probably needs to know that.
 18 So, you know, we at the Department would
 19 certainly support and probably would
 20 independently let that information out at some
 21 point in the future after the deadline, if there
 22 was service and we could not do it. What I
 23 would hope is that if we had to do that, this
 24 would also pressure communities to come up with
 25 dollars to give to their services who, if it's a

1 announcing that this would indeed take place,
 2 and advisories have been reworked to include
 3 this motion which we will send out too, but more
 4 timely, a letter from the Department will go out
 5 notifying ambulances. And the work we did
 6 earlier was to remove ambiguity, if there was
 7 some, about extensions, or what would that mean,
 8 what would an extension mean. That was our
 9 attempt at the previous motions.
 10 MR. WRONSKI: If I might mention,
 11 although this is a proposed motion, it certainly
 12 I think would be useful to hear comments from
 13 the tables since everybody's here, both voting
 14 and non-voting members, a significant number of
 15 you, about the recommendation to do a more
 16 public release of information. I know at the
 17 State Council that will be discussed tomorrow,
 18 and the cap – the wave form has already been
 19 approved at that level. From a Department
 20 perspective, we certainly don't need to have an
 21 approved motion to do that. We can make a
 22 decision, as the body that regulates the
 23 industry, that this is appropriate to do. I
 24 want it for the record that I made it very clear
 25 that when a segment of our EMS system cannot

1 purely financial reason, could come up with the
 2 dollars to support the equipment. But we think
 3 it's very important, and we support that, you
 4 know, public notice.
 5 DR. MARSHALL: Any other questions?
 6 Dr. Funk.
 7 DR. FUNK: A lot of these issues
 8 that are coming out of Medical Standards are
 9 really quite important, and with the big break
 10 that we are going to have between now and the
 11 next meeting at the end of September, I guess my
 12 question is can these issues, these votes coming
 13 out of Medical Standards, go to the Council
 14 tomorrow without having a quorum to vote on them
 15 here?
 16 MR. WRONSKI: Well, I don't have an
 17 absolute firm answer on that. Let me equivocate
 18 and say that I'll see if I can get an answer.
 19 The State Council independently – and in the
 20 statute. The statute was never changed. It
 21 says the State Council shall, you know, develop
 22 and approve not just SEMAC's determinations but
 23 it independently always was, you know, the body
 24 that set medical standards prior to the creation
 25 of the SEMAC. However, the statute then built

1 in the SEMAC to be that body to make its
2 recommendations. So the question is, now that
3 we've modified the law somewhat, is it possible
4 for the parent body to independently go ahead
5 and approve something they know is in discussion
6 at the SEMAC level to expedite it. I'll see if
7 I can get an answer. I'll make a call to
8 Council's office and see if they can tell me,
9 but it's a good suggestion.

10 DR. FUNK: This is assuming we have
11 a quorum tomorrow.

12 MR. WRONSKI: Yes, assuming we have
13 a quorum tomorrow. Just for the record, we only
14 missed a quorum today by one physician.

15 DR. HENRY: We were very
16 conservative. It was eight and eight, so we
17 read the by-laws as having a majority. But I
18 would say, Dr. Funk, with respect to this issue
19 that you raised – that we just raised, if we
20 think back on the deliberations this morning,
21 Andy read the minutes from the SEMSCO meeting
22 which ratified the SEMAC motion of providing
23 continuous monitoring after patients are
24 intubated. There was a modification, I believe
25 at SEMSCO, and that was the interpretation

1 whether regions could have, if not a waiver, a
2 process to allow lengthening of time. Okay?
3 That did not come out of the SEMAC. That came
4 out of the SEMSCO. That is part of the
5 relationship. Sometimes we've had votes go
6 forward, and SEMSCO said, okay, you made – that
7 might be medical policy but there are
8 operational or other reasons that we don't feel
9 we can vote on this, for those reasons. It's
10 sort of a balance. But if I look back on that,
11 that motion that Mr. Ehrhardt read into the
12 record, or that understanding, was a
13 modification of the SEMAC motion. What SEMAC
14 did this morning was to clarify what really what
15 was the intent of what a lengthening of time
16 would mean. And it would mean, I would take it,
17 to use a bag valve mask if you can't assure
18 continuous monitoring. So that means more of a
19 medical standard, a patient safety issue. For
20 other votes, it may have a different
21 interpretation, but on that one that's –

22 DR. MARSHALL: Are there any other
23 questions on those protocols?

24 Other discussions that took place, we've
25 been trying to put together a state formulary.

1 We started working on that. We have a grid that
2 we've developed. We're still missing eight
3 regions, but so far, of the 10 regions'
4 formularies, there are a total of 60 different
5 medications that are available statewide. Most
6 of the doses are in pretty much the same range.
7 When I looked at the various regions and the
8 dosages of the medications they were using, they
9 were in similar ranges. Some medications that I
10 didn't expect, ephrine or neosynephrine; that
11 was one. It's available in a couple of regions.
12 The other one was – actually, nitrous oxide is
13 available in a couple of regions. We had a
14 discussion about that this morning. There was
15 one other but I – ipecac is still on one
16 region's formulary. So there's a wide range of
17 medications that are being used by the different
18 regions, and we would like to try to get all of
19 these together, so please, if you haven't
20 submitted your formularies, please do so, so we
21 can include it in the grid.

22 In addition to that, we also need to
23 receive your ALS and BLS protocols. There have
24 been occasions where we've come across protocols
25 that slip through so we want to make sure we

1 have a fresh copy of everybody's protocols, both
2 ALS and BLS, and there are about eight regions
3 that still need to submit those.

4 We also had some discussion on
5 Department of Health Policy 9605, which had to
6 do with the use of cats under veterinary control
7 for training and intubation, pediatric
8 intubation in particular. We did have some
9 discussion on that and the usefulness of it in
10 the current times. And Medical Standards felt
11 that, you know, at the present time, since this
12 may be one mechanism of training paramedics on
13 intubation techniques, that we continue to leave
14 this policy in place for now and come back and
15 look at it again in the future, if it's needed.
16 A lot based upon perhaps technology and human
17 patient simulation. That seems to be getting
18 better.

19 We had some very quick discussion.
20 Maybe Dr. Henry can enlighten us on the use of
21 Atropine?

22 DR. HENRY: All right. We
23 distributed the Atropine pens, because Mark I
24 kits were too expensive, so we bought Atropine
25 pens. You remember, right? So they were

1 distributed to the regions. We had a lot of
 2 talk about this. Should we buy them? We did
 3 buy them. They were bought. And how would they
 4 be used? And we distributed literature that it
 5 might be effective to have Atropine along; it
 6 was better than nothing. And we got queries
 7 from some regions of what would the training be
 8 for use if one had Atropine alone. My
 9 remembrance, though, it wasn't in the formal
 10 vote, and the record was we said we would use
 11 the same protocols we had for the Mark I kits in
 12 terms of minor, moderate, severe – dosages, and
 13 we would administer Atropine as we would if we
 14 had Atropine and Pralidoxime, but we would only
 15 have one drug, better than none. And that – I
 16 conferred again with Dr. Hoffman from the New
 17 York City Poison Center. He agreed that would
 18 be prudent. He was available if we had chosen
 19 to phone conference with him today with any
 20 queries. We brought this up late, but I think
 21 that's what people assumed we were doing. If
 22 there is any discussion about that, we should
 23 have that now.

24 DR. MARSHALL: I just have some
 25 information about that. To date, 16,752

1 obviously, the other beneficial thing is you get
 2 training. Whether or not we do get approval for
 3 resupply, the training is out there, it has been
 4 had. Potentially, you know, in the future that
 5 would be beneficial to providers.

6 DR. HENRY: Yes, Mr. Hassett.

7 MR. HASSETT: Along the lines of
 8 the Atro-Pen, I would just ask that it has come
 9 to our attention down in Nassau that the
 10 manufacturer of the Mark 1 kits is no longer
 11 manufacturing them and is instead manufacturing
 12 something called a Duo Dote, which is the
 13 combination of Twopam and Atropine mixed into
 14 one injector, as opposed to the Mark 1 that has
 15 two separate injectors. And the inquiry is that
 16 it's coming up as, will the state council be
 17 doing anything to approve the use of the Duo
 18 Dotes to replace the Mark 1 kits?

19 MR. WRONSKI: It's a good question.
 20 I had briefly heard something about a single
 21 pen, but I don't know any of the details. The
 22 question would be is this at this point has that
 23 particular pen been adopted by the feds? Has
 24 the FDA looked at it, or is any of that – and
 25 I'm presuming, if somebody's contacting people,

1 Atropine auto-injectors have been distributed to
 2 20 counties with 388 agencies attending
 3 training. Eight counties are scheduled for
 4 training and distribution in the next three
 5 weeks, and this is dated 5/28. Twenty-four
 6 other counties are getting back with dates for
 7 training. The program seems to have been well
 8 received in the EMS community. It has also been
 9 beneficial to the EMS coordinators and the
 10 agencies in terms of what is available in the
 11 Chem Packs. The drugs that are now being
 12 distributed expire April of '09, so they're
 13 looking at replacement mechanisms for those.

14 MR. WRONSKI: If I could just
 15 comment? One of the things, the unexpected
 16 results of the training is we did find out that
 17 many EMS agencies had no real information, at
 18 least in their heads, about the Chem Pack and
 19 how it all worked, and that this was an
 20 opportunity to have people in a room from a
 21 given county who could then ask questions and
 22 understand what is available in their county and
 23 how well that works. We had presumed that that
 24 was at this point well-known. We were wrong, so
 25 that was a very beneficial thing. And,

1 it's at least had FDA approval; would that be
 2 right?

3 DR. MCEVOY: Probably got some in
 4 his car.

5 DR. HENRY: Dario, do you have some
 6 information about this?

7 MR. GONZALEZ: Dario Gonzalez.
 8 Actually, what you're saying is true. After the
 9 next year or so, the Mark I's will not be
 10 manufactured anymore. You will have to buy the
 11 Duo Dotes, and they will be phasing out Mark
 12 I's. And, of course it will be made by
 13 Meridian, the same manufacturers of the Mark I.
 14 The price is probably comparable. It's a little
 15 bit more, I believe. It's a single joint
 16 Atropine II pen, so you will be getting the two
 17 pens with that together. It doesn't help you as
 18 far as the Atro-pens, as far as Atropine backup,
 19 so if you're just going to use Atropine, you can
 20 still, as far as I know, get that, and they'll
 21 be coming forward with that. So you won't be
 22 able to get the Mark I's after a while.

23 DR. HENRY: Any other comments on
 24 the Atropine distribution? All right.

25 DR. MARSHALL: The other thing that

1 came up, there was some discussion about based
2 on Mr. Wronski's discussion of the State EMS
3 standards, and how we put those standards out in
4 what format, and there will be some discussion
5 this summer, and whether those standards come
6 out in a format of a narrative, describing what
7 the standards are, versus a protocol, which
8 we're all more comfortable with in terms of
9 looking at and following protocols. So that
10 will be one of the things that we'll discuss
11 over the summer.

12 Also, in terms of that is the question
13 came up and was raised about if regions must
14 follow the State standards, why does the region
15 have to go through the protocol approval process
16 and send out protocols to various stakeholders
17 within the regions? So we had quite a bit of
18 discussion on the importance of involving
19 stakeholders and end users of the protocols in
20 the protocol – not only the protocol approval
21 process, but the protocol development process
22 which was pointed out that, you know,
23 specialists needed to be involved in the
24 development process as well as the approval
25 process. So those will be ongoing discussions

1 each service but rather to allow the Department
2 of Health to develop an electronic reporting
3 form necessary to receive regional data and to
4 allow us to focus on NEMSIS compliance as a
5 state. It's anticipated that the award is being
6 announced in September, so we look forward to
7 hopefully winning that award.

8 It was also reported that there is
9 currently an ample supply of PCRs in the State's
10 warehouse with more PCRs on order to prevent any
11 possibility of running out. Everybody should be
12 made aware that the two-page BLS First Response
13 Agency PCRs will no longer be printed. Folks
14 have been advised to use whatever current supply
15 they have – the transition, BLS FR agencies to
16 a three-page report.

17 2006 PCR data is being worked on, and we
18 expect release of that data shortly. It looks
19 like it's going to emerge as the most robust
20 data set in the history of the State Health
21 Department and includes a first-time comparison
22 with the SPARCs data. And Mr. Gallagher, from
23 the School of Public Health, reported that he's
24 been doing a lot of work in matching PCR data to
25 SPARCs data for 2005 and 2006, and was actually

1 over the summer, also. With that, that's my
2 report.

3 DR. HENRY: Thank you. Mr. Delagi,
4 do you have anything to bring forward today?

5 MR. DELAGI: I do indeed. Thank
6 you, Dr. Henry. I just wanted to bring you up
7 to date on a couple of our ongoing projects.

8 DR. HENRY: This is from the
9 Quality Improvement Group that meets?

10 MR. DELAGI: The IRB and EMS gave
11 their report, and that included some rather
12 significant progress in some of our ongoing
13 items that I've been reporting over the last
14 several meetings.

15 In response to initiatives contained in
16 the Strategic Highway Safety Plan and based on
17 some of our own discussions about electronic
18 reporting format and NEMSIS compliance, the
19 Bureau staff reported that they've submitted a
20 grant to the Governor's Traffic Safety Board –
21 a grant application, excuse me, to the
22 Governor's Traffic Safety Board to solicit the
23 funding mechanism for developing some of these
24 projects. It was made clear that the funding
25 shouldn't be one – would not be used to fund

1 impressed with the high degree of concordance
2 between prehospital impression and principal
3 diagnoses code by the Emergency Department.
4 Very interesting finding, very interesting
5 indeed. And he's looking at, you know, a
6 promising report based on those preliminary
7 results.

8 A couple of additional CQI rollouts done
9 by myself or Lee Burns in different parts of the
10 State; it looks like we have about 16 of the 18
11 regions saturated with this rollout so far.

12 The Bureau staff also reported that the
13 RFI for the electronic reporting format was
14 nearly complete, and it includes components for
15 design and implementation of specific templates
16 for reports that will be used by either regions
17 or by the State Health Department, and also used
18 to develop a system for looking at prehospital
19 care by developing a prehospital care patient
20 registry.

21 Just wanted to quickly bring you up to
22 date on our ACEP partnership. I was able to
23 attend, along with Miss Chiumento and Miss
24 O'Connor, a meeting with the ACEP EMS Committee
25 at their regional meeting in New York City on

1 May 2. I was very, very impressed by the amount
 2 of – I don't know how you say it. They were
 3 very, very enthusiastic, very, very energetic in
 4 terms of their willingness to cooperate with us
 5 on this project. And apparently, the message
 6 that we sent out, along with other States,
 7 really made them stand up and take notice. And
 8 they reported to us that, unlike in previous
 9 years where ACEP at the national level would use
 10 national data sources, which we know usually
 11 contains dated information, this year they're
 12 actually going to the states directly and asking
 13 the states to comment on the things that relate
 14 not only to EMS, but to the health care system
 15 in general. We took that as a very big win, and
 16 we'd like to think that that was, in part, due
 17 to what we, as a group, can put forth to them.

18 Their board had another –

19 DR. HENRY: I want to just say, I
 20 appreciate your efforts and your committee's
 21 efforts and Dr. Kaufman's contact with
 22 Dr. Fidler, because one of our first queries
 23 when we got our report card a couple years ago
 24 was how did they get these scores on us. So we
 25 had to search or ask where was the database that

1 painted us a C in this area, or a B minus, and
 2 it sounds like you made good movement on that.

3 MR. DELAGI: Thank you. One of the
 4 votes that the group took was – they agreed to
 5 continue to work and support the partnership
 6 that we've been forging, but they felt that it
 7 would not be appropriate to do the state of the
 8 State of New York EMS along in parallel with the
 9 national ACEP report card, because they didn't
 10 want one to overshadow the other, or one to get
 11 lost in the other one. So we agreed
 12 conceptually that the ACEP national report card
 13 would really be a homogeneous look across the
 14 country about global health care issues that
 15 plague the health care industry countrywide and
 16 taking a look separately at the state of the
 17 state of EMS in New York using very contemporary
 18 and very valuable data that we know that we can
 19 collect. So the recommendation, after reviewing
 20 that data, would lead to a white paper that
 21 would be suitable for presentation to the Health
 22 Commissioner, to REMSCOs, to program agencies,
 23 and to other people, and we're working on that
 24 actively with a series of work items, which I'll
 25 get to in a second. But I did want to let you

1 know that the ACEP's priority issues, basically
 2 what happened is, national ACEP went to each of
 3 the state ACEP's committees and asked them to
 4 identify their five problem areas. And in New
 5 York our chapter wanted to look at hospital
 6 emergency department crowding, availability of
 7 specialties, growing numbers of underinsured and
 8 uninsured, comprehensive malpractice liability
 9 reform, and reimbursement issues as the five top
 10 priority items in New York State.

11 And then for our state of the state of
 12 EMS, you all remember the proposed data points
 13 that we had looked at, looking at PAD programs
 14 in terms of how many days there are per
 15 population, where they are and so forth, the
 16 emergency medical dispatch, an enhanced 911,
 17 system response, care provided, quality
 18 improvement and medical direction. And each one
 19 of those we talked about before, so I don't want
 20 to rehash that with you, but what is important
 21 to know now is that, in addition to having one
 22 of our committee members assigned to each one of
 23 those work items, we now have an ACEP committee
 24 member that's partnering up to collect that
 25 data. And we've had several successful data

1 runs already where we've been able to take a
 2 real critical look at medical directors, for
 3 example, to identify which services have medical
 4 directors, which services don't, and we're
 5 pleased to report that there are probably only
 6 three in the State that do not have a physician
 7 associated with them. That was a very
 8 interesting finding. And we're also taking a
 9 look by physician name to see how many services
 10 and/or technicians that they're looking at.
 11 That's just one example.

12 One of the clinical things we wanted to
 13 look at, as you recall, was analgesia,
 14 prehospital analgesia, and our work committee
 15 put together a very nice survey to identify
 16 that.

17 And we have a couple of other things
 18 that are going on. Communications folks are
 19 taking a look at P-CEPS that provide emergency
 20 medical dispatch, and I think the number is
 21 hovering around 97 percent of the P-CEPS, across
 22 the entire State are doing emergency medical
 23 dispatch. So we are having a lot of progress to
 24 report and a lot of exciting things going on.

25 Lastly, we're about to conclude the data

1 collection for the air medical TAG's helicopter
2 appropriateness survey. The data collection
3 ends on May 31, and we have two milestones after
4 that. We're asking that each air medical
5 carrier get the data sheets to their respective
6 program agencies by June 13 and have each
7 respective program agency get it to the Bureau
8 by June 30. And then our committee and the air
9 medical TAG Committee will spend the summer
10 taking a look at the data, analyzing it, and
11 coming up with a report to be presented at the
12 September meetings.

13 And then, lastly, we've asked our
14 committee to take a look at what projects might
15 be of interest in 2009 session. The one thing
16 we know that we're going to do, is do a survey
17 of the agencies to try to gauge the impact of
18 the QI rollouts to see how successful those
19 rollouts and the manual have been. But beyond
20 that, we're looking for ideas of things that you
21 may want to study in 2009. And that is my
22 report.

23 MR. WRONSKI: If I could just
24 comment, there is a lot of growth in the last,
25 probably, three years in the State of New York

1 in the availability of data, both the old data
2 that's clunky and comes through the paper PCR
3 and the growth of electronic data. I think the
4 QI Committee is going to have a very, very –
5 and it always has, but it's going to get a more
6 important role as we move along because one of
7 things that I'm going to be looking for, and I
8 think the SEMAC wants to look at, and I know,
9 you know, briefly in discussions with both
10 Dr. Henry and Dr. Marshall, using the data to
11 see how we're doing and that's now a possibility
12 to take a look at that and starting to match the
13 hospital data. I think that's very exciting,
14 you know. I think we walked gingerly, initially
15 through this but over the next couple of years,
16 I think New York State will finally start to be
17 able to really do a true Quality Improvement
18 analysis of what the system is doing and how
19 we're doing it. Thank you.

20 DR. HENRY: Are there any items to
21 discuss from the Education Committee?

22 DR. MCEVOY: I can give a brief
23 synopsis. They're going to bring – actually
24 one motion needs to come here, which is to
25 approve two PAD curriculums. I think it also

1 goes to the SEMSCO tomorrow, right? But they
2 received a curriculum from Emergency Care and
3 Safety for the people that write the ALS
4 curriculum and they also got one from a company
5 called, Emergency First Response. And both of
6 those were reviewed by Bureau staff and found to
7 be compliant with the AHA guidelines so they're
8 recommending those curriculum be approved.

9 The other motion, I'll get to in a
10 second. They had a couple of Tag reports. The
11 Specialty Care Curriculum Tag is at a point
12 where they're looking for some physician input
13 as well as Bureau input on their Critical Care
14 Transport Course curriculum and I think that
15 they're going to move forward to obtain both of
16 those. The CLI Curriculum Tag is evolving their
17 development of the Certified Lab Instructor
18 curriculum and looking at some standardization
19 across the board in order to finalize that. The
20 Safety Tag gave a brief report. The items that
21 they mentioned were; a policy statement
22 regarding seat belt use in ambulances and in
23 emergency ambulance service vehicles, an
24 advisory on high-visibility garments which we've
25 heard about, that will be coming forth from the

1 Bureau. They're still continuing work on an
2 incident reporting form and I guess we're going
3 to see some draft of that at some point in the
4 near future and there is a curriculum review
5 that they presented of – (inaudible) curriculum
6 and some areas where safety could be added into
7 that, so that Education and Training Committee
8 will take that under advisement and see what
9 changes they might want to incorporate. The
10 next motion comes from the Instructor
11 Requirement Review subcommittee, which announced
12 that they had changed their name to that name
13 from the Aging and Disability Tag. They were
14 asked to look into aging instructors and the
15 requirements for them to continue teaching and
16 in conjunction with that, they did a survey of
17 core sponsors throughout –

18 DR. HENRY: Is this the Florida
19 course?

20 DR. MCEVOY: So, they surveyed core
21 sponsors and by their report, to call the
22 response, passionate, would be a gross
23 understatement. From their survey they found an
24 average age of an instructor was 46.3 years old;
25 the range being from to 20 to 69. About half of

1 the core sponsors had faculty over 50, about a
 2 quarter of them had faculty over 60 years old
 3 and essentially, the overwhelming response was
 4 that the current requirement that people
 5 actively participate in riding with a
 6 prehospital service in order to maintain their
 7 teaching credential should be changed. So,
 8 they're proposing, and what comes forward as a
 9 seconded motion from Training and Education, is
 10 to remove the statement that says you must be
 11 currently, actively providing prehospital care
 12 while with an agency from the requirements for
 13 CIC certification renewal. So, that would just
 14 be for the Certified Instructor Coordinators,
 15 the people that run the courses, not for the lab
 16 instructors, and it would only be at their
 17 renewal point, so they would still need to be
 18 riding with an agency in order to get their
 19 original certification. And the feeling is that
 20 that would affect a significant number of
 21 instructors, probably a quarter of the
 22 instructors in the renewal process. And to
 23 answer peoples' question as to whether that
 24 would make a change with folks who we've lost
 25 over the years, it is possible for people under

1 March 31, need to get their final vouchers in to
 2 the Bureau by the June 16, or not get funded for
 3 those courses, so we'll try to get that word
 4 out. And then there was also some discussion on
 5 changing the testing requirement for faculty so
 6 that it would be lower than the currently
 7 required 85 in order to continue to hold their
 8 teaching credential. And I think they were
 9 going to form a Tag on chromosomally-challenged
 10 individuals but they decided not to address that
 11 issue at this point. They wanted to leave it
 12 where it is. That's it.
 13 DR. HENRY: All right, thank you.
 14 MR. WRONSKI: Just a comment on
 15 the – our older and wiser instructors and the
 16 issue there. I applaud the Education Committee
 17 for moving along with that. Just to make it
 18 very clear, the issue always was, does an
 19 instructor have to be, you know, full-time
 20 riding provider in order to be able to teach.
 21 And the consensus, I think coming out all of
 22 these groups is, that, no. You need to have
 23 been a significant provider in your career but
 24 there's an awful lot that you offer to students
 25 as you get older and your kneecaps no longer

1 that to come back and to begin teaching again by
 2 going through the usual renewal process. So
 3 that motion, I guess, will come forward tomorrow
 4 to SEMSCO as somewhat of a solution to the aging
 5 disability situation.

6 I think the other key points were, you
 7 may not believe this, but the spinal
 8 immobilization material came out and they had to
 9 administer smelling salts to a number of people
 10 in the room. It was actually handed out. It
 11 has been mailed out and people have actually
 12 received it in the mail. There was some
 13 discussion about draft 3.0, the National
 14 Educational Standard. Comments are due back on
 15 that by May 30 and it appears, at this point, as
 16 though the big job is coming and that's the job
 17 for the states, such as this committee, to
 18 interpret those guidelines into actual
 19 curriculum. And I think that final piece of
 20 that will be out in the fall and that's when
 21 that work will begin. So, there is some angst
 22 about that process and how we're going to move
 23 on it.

24 There was a note from the Bureau that
 25 classes who are tested, have tested prior to

1 allow you to lift 150 or 250, or in this age of
 2 bariatric patients, 450-pound patients. That
 3 becomes difficult. But you, as an instructor,
 4 there are things you know and can teach that the
 5 younger instructors still need to learn. So, I
 6 think the compromise and the work on this is to
 7 be applauded.

8 DR. MCEVOY: There may be some
 9 advertent benefit of that as well, in that
 10 people who find themselves as lab instructors
 11 aging out, may decide to move to become
 12 Instructor Coordinators because they would no
 13 longer have to have that requirement if they
 14 were to do that, so there may be some benefit to
 15 that as well, which we don't anticipate.

16 DR. HENRY: All right, good.
 17 Mr. Delagi.

18 MR. DELAGI: Just a quick question.
 19 Can you give us a little insight as to what the
 20 discussion was and why it's CIC only and not
 21 CLI?

22 DR. MCEVOY: Yes. The main group
 23 that that affects tends to be, when you actually
 24 look at their roles in the classroom is, CLI is
 25 an individual who needs the physical agility to

1 be able to get down on the floor and work with
 2 students, work with the equipment, and actually,
 3 probably is an individual who needs to still be
 4 actively riding in order to do the skills that
 5 they need to do in class. The CIC is a person
 6 who coordinates the course, does lectures and
 7 probably doesn't have those same needs.
 8 MR. DELAGI: Okay, thank you.
 9 DR. HENRY: Is there any unfinished
 10 business? Well, I have one unfinished business
 11 and that's just to make sure that the – Warren
 12 asked the Safety Group to consider what actions
 13 were needed in a moving vehicle that would –
 14 you covered that?
 15 DR. MARSHALL: No, that's why I was
 16 –
 17 DR. HENRY: Oh, okay. That's new
 18 business. All right, I defer. New business.
 19 Any other unfinished business? New business?
 20 DR. MARSHALL: As Dr. Henry was
 21 just starting to say, I got an e-mail from the
 22 SEMSCO Safety Tag, asking us to – asking
 23 Medical Standards to look specifically to
 24 providing some guidance for providers as to the
 25 type of medical interventions that should be

1 patients that basically have a 1.5 percent
 2 survival rate, you know, to survive
 3 neurologically intact, maybe we should think
 4 about that.
 5 DR. HENRY: All right. Any other
 6 new business? Yes.
 7 DR. OLSSON: More of a guidance and
 8 recommendation issue. There is, since we passed
 9 the standing order of Morphine in the region,
 10 we've got many physicians who are receiving the
 11 patients in the ED and refusing to sign for the
 12 Morphine that was given under standing order.
 13 They've had no problems signing for the
 14 Benzodiazepines for seizures but they are
 15 flat-out refusing to sign for it and it's
 16 putting some providers in an uncomfortable
 17 position and I'm looking to see how other people
 18 have addressed that. Does the State still
 19 require a signature on the PCR? When we go to
 20 electronic PCRs, if that's an issue, can there
 21 be a default where my signature goes on it?
 22 DR. HENRY: Well, my opinion would
 23 be, whenever there is a standing order and it's
 24 a drug you administer through a physician, there
 25 is one physician's name who would appear. And

1 performed regardless of the provider's ability
 2 to properly restrain themselves in a moving
 3 vehicle. So, that's something that Medical
 4 Standards will look at. And I would ask that
 5 Dr. Henry to ask somebody from SEMAC to also
 6 participate so that we can come up with some
 7 reasonable guidelines as to what providers
 8 should or should not be doing in the back a
 9 moving vehicle or what procedures should delay
 10 the movement of the vehicle. If you need to do
 11 a procedure, maybe you shouldn't move the
 12 vehicle until you're finished. So, those are
 13 the types of things that we'll look at also over
 14 this very busy, coming summer.
 15 DR. HENRY: Craig.
 16 DR. VAN ROEKENS: Yeah. I would
 17 just like to add, I think that there are a
 18 number of things different agencies or regions
 19 can do in this regard. One of the devices that
 20 is out there now is a vest – (inaudible) does
 21 CPR – (inaudible) they say it's prohibitive.
 22 There are other issues in terms of the way that
 23 that medication is administered. There is CPAP
 24 that can be used as opposed to intubating
 25 patients and if we're, you know, rushing

1 if it's an agency, then it's that agency's
 2 Medical Director because that's the person most
 3 responsible for standing orders, so that's not
 4 the person who receives the patient. They may
 5 or may not have ordered the drug or have
 6 anything to do with the agency in caring for the
 7 patient. And that's my – that would be my
 8 opinion.
 9 DR. YOUNG: Are you having trouble
 10 with him signing the wasting forms and all that?
 11 Do the agency Medical Directors handle that?
 12 Because they're supposed to.
 13 DR. OLSSON: In signing the PCR, or
 14 the CCR at the hospitals.
 15 DR. YOUNG: Yeah, but what about
 16 the other forms, the actual controlled
 17 substances forms? Are you having difficulty
 18 getting those filled out by your Medical
 19 Director, your Medical – Agency Medical –
 20 DR. OLSSON: You're referring to
 21 the additional form that is in the ED?
 22 DR. YOUNG: No, the forms that stay
 23 with the agency. I mean, with the care and
 24 control substances –
 25 DR. OLSSON: I've never heard that

1 that's been an issue. It's only been upon
 2 delivery or receipt of the patient in the ED.
 3 So, that's –
 4 DR. MARSHALL: All right. Are the
 5 physicians signing that – or refusing to sign
 6 that they received the patient, or are they
 7 refusing to sign because the patient was given
 8 Morphine?
 9 DR. YOUNG: Refusing to sign
 10 because they were given Morphine.
 11 DR. HENRY: Maybe they
 12 misunderstand what they're signing.
 13 DR. OLSSON: Well, that may very
 14 well be. I don't know if a signature is
 15 required in a – region. There is no signature
 16 required for that.
 17 DR. HENRY: That you receive a
 18 patient.
 19 DR. MARSHALL: We have a sign-off
 20 spot for the receiving agent or the hospital but
 21 there is no requirement for the hospital to sign
 22 that but we do.
 23 DR. OLSSON: The only signature
 24 that physicians do routinely is if a controlled
 25 substance was given.

1 Or State Ed laws, or something that require it.
 2 But we're sort at their mercy because they're
 3 not going to help us and nobody's getting
 4 controlled substances, so –
 5 DR. HENRY: All right, any other
 6 new business? Yes, Mr. Hassett.
 7 MR. HASSETT: Just one. Possibly a
 8 request for the SEMAC that maybe the SEMAC could
 9 request the Commissioner of Health to speak to
 10 his hospital division to ask that the hospital
 11 division speak to their Emergency Departments in
 12 the hospitals around the State and ask that they
 13 have wave form capnography available in the ED's
 14 so when these ambulances that on January 1, roll
 15 in, they have someplace to plug it in, so we had
 16 continuity of care for the patients.
 17 DR. HENRY: Well, you know, we –
 18 you can speak to us about that because this
 19 group actually is working on standards for
 20 EDARs, and one of the things we discussed was is
 21 there equipment needed today that didn't exist
 22 before, and there are different minds on that;
 23 one is that people would normally just acquire
 24 such equipment, and others is that it's better
 25 to be proscriptive if you want to assure it.

1 DR. HENRY: What does it mean when
 2 you sign them?
 3 DR. OLSSON: The assumption was,
 4 that it's an acknowledgment that the controlled
 5 substance was given and the understanding, as
 6 misguided as it may be, was, isn't this a
 7 requirement by – so, this is a whole thing that
 8 doesn't need to be a big deal.
 9 MS. BURNS: Lee Burns from the
 10 Bureau. Part 8136 does not require a physician
 11 to actually sign the document. Your local plan
 12 may. Each – the code requires that each
 13 service put together an operational plan for the
 14 use and then just from an inventory
 15 administration record perspective, the services
 16 plans, and a lot of them have developed
 17 conjoined services plans, may require that, but
 18 it's not required by code.
 19 DR. OLSSON: That answers it.
 20 DR. BILLITTIER: We have the same
 21 requirement for the agencies that get controlled
 22 substances from our hospital and it's because
 23 the pharmacist put it in place. My question I
 24 guess is, is there some other regulation
 25 somewhere in the pharmacy laws? I don't know.

1 But if you go back 35 years ago, people would
 2 say that hospital care got transformed by having
 3 standardized prehospital care, at least in the
 4 cities, because people came in treating patients
 5 a certain way. It got the attentions of the
 6 doctors in the ER, and if they made it, they got
 7 the attention of the people in the units, and it
 8 really – it was true. I mean, Shelly Jacobson
 9 taught me that at Jacobie. People are still
 10 active on the committees. And I think we'll see
 11 what you're talking about with wave form,
 12 because it should be more present wherever
 13 people are intubated, and it will be, and we may
 14 be a little ahead of the curve right here where
 15 we should be in the ER's, but your point is
 16 well-taken.
 17 MR. HASSETT: Well, yeah, that was
 18 generated by the fact that in Nassau we created
 19 an Emergency Department Directors Committee on
 20 the Council, and this issue came up there when
 21 we advised the ED directors that there was going
 22 to be a requirement for the ambulances to have
 23 wave form capnography when they – as of January
 24 1. And we put out that possibly the hospitals
 25 may want to consider doing that for the ED's,

1 and the suggestion from a number of the ED
2 directors was that it would be good if something
3 came from the top down, meaning from the Health
4 Department down, saying that this should be
5 something that we should be looking at because
6 it would make it easier for them to get their
7 CEOs to fund it.

8 DR. MCEVOY: There is a joint
9 commission requirement for hospitals that they
10 use wave form capnography while they're
11 transporting a patient, so the ED has got to
12 have some capabilities if they're moving some
13 patients.

14 DR. OLSSON: Should we give the
15 hospitals the same January 1 deadline? They
16 can't intubate after that.

17 DR. HENRY: Well, actually that's a
18 good idea, in a way, Dr. Olsson, because if we
19 wanted to take some action, one could notify
20 hospitals that this will be a requirement on
21 intubated patients after January 1 and to give
22 them a heads-up to prepare to receive and
23 maintain that standard of care, so I think there
24 is a good opportunity.

25 SPEAKER: So, they'll extubate them

1 prior to leaving?

2 DR. HENRY: Hopefully, right? We
3 can only hope, before they walk out.

4 DR. MCEVOY: Nice.

5 DR. HENRY: Any other new business?
6 I just want to say for the record that, you
7 know, maybe we should consider by-law changes,
8 to have alternates available? I'm a little
9 saddened that we couldn't vote. On the other
10 hand, I want to reflect that we have two medical
11 directors from New York City present here at the
12 meeting, so I don't know where Dr. Kaufman is,
13 why three of you couldn't come, but it's not
14 like the City is not represented at the table.
15 And there is, you know – here you are from
16 other regions who have been coming faithfully,
17 waiting to be vetted, so you are present. We
18 even dragged the Commissioner of Health back
19 from Erie so he could have your vote, the vetted
20 member, so it's not like we don't have presence.
21 But it's important, you know, I suppose for all
22 of us to look at our regions and encourage our
23 people to come, now that we can't quite – we
24 can't sit the alternate as a county member, but
25 I appreciate your presence. I think the

1 discussions are very important, and thanks for
2 coming.

3 Are there any other – any
4 announcements?

5 All right, our next meeting is then
6 September 10, so we'll see you then. And I'll
7 take a motion to adjourn.

8 DR. MARSHALL: So moved.
9 (Whereupon, the proceedings, in the
10 above-entitled matter, concluded at 3:57
11 p.m.)

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2 CERTIFICATE

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

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Kyle Alexy

DATE: May 31, 2008

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