NEW YORK STATE EMERGENCY MEDICAL ADVISORY COMMITTEE

(SEMAC)

December 2, 2008
1:45 p.m.
Best Western Sovereign Hotel
1228 Western Avenue
Albany, New York

APPEARANCES:
Mark Henry, MD
Arthur Cooper, MD
Michael Dailey, MD
Timothy G. Haydock, MD
Bradley Kaufman, MD
August J. Leinhart, MD
Lewis Marshall, MD
Daniel Olsson, DO
Craig Van Roekens, MD
Sharon Chiumento
John Hassett
Robert Delagi
Marjorie Geiger
Edward G. Wronski
Anthony Billittier, MD
Joshua Kugler, MD
John Broderick, MD
Michael McEvoy

Mark Zeek
Michael Mastrianni
Carl Goodman, M.D.

1 DR. HENRY: Okay, I'd like
2 to call our meeting to order. I
3 would ask members of the SEMAC to
4 take a seat, and I'd also ask any
5 members who may not yet be
6 officially vetted as members of
7 SEMAC, but who are potential
8 members, to come to the table too.
9 Okay?
10 So we can take a roll call
11 please of our membership.
12 (Roll call was taken.)
13 DR. HENRY: Okay, and then
14 I'd ask any members at the table who
15 were not called but will be official
16 members soon that you identify
17 yourselves for the record?
18 DR. DAVIDOFF: Jack
19 Davidoff, Finger Lakes Region.
20 DR. COOLEY: Craig Cooley,
21 Western Region.
22 DR. HENRY: Anyone else?
23 Okay, thank you.
24 Okay, the first item of

1 business is approval of minutes from
2 the last meeting. Are there any
3 corrections to the minutes, Sharon?
4 MS. CHIUMENTO: Page 7,
5 line 20, facing should be pacing;
6 page 11, line 11 mean should be
7 lead. Oh, by the way, the pages
8 were not numbered, so you have to --
9 I started with the first page with
10 actual writing on it. Page 17, line
11 18, Dr. Hassett is Mr. Hassett.
12 Page 28, line 12, S-A-P should be
13 S-A-T for 02 saturations. Page 49,
14 50 and 55 there's multiple instances
15 where N-E-P-S-I-S should be
16 N-E-M-S-I-S, N-E-M-S-I-S. Page 51
17 and 52, multiple places A-S-E-P
18 should be A-C-E-P; page 54, line 9,
19 P-E-E-R is P-I-E-R for P-I-E-R
20 committee; page 57, line 12, M-T-S-A
21 should be M-H-T-S-A; and page 95,
22 line 8, E-M-A should be E, Nancy,
23 N-A, E-N-A.
24 DR. HENRY: Okay, anyone

1 else have any additions,
2 corrections? Hearing none, a motion
3 to approve the minutes with those
4 corrections? Second? All in favor?
5 SPEAKERS: Aye.
6 DR. HENRY: Opposed?
7 Okay, thank you.
8 All right, I have a receipt of
9 a copy of a letter sent to Mr.
10 Wronski from Dr. Dailey from the
11 REMO region with a query about EMTs
12 and paramedics having to provide
13 care in emergency departments when
14 there's a delay in transfer of the
15 patient to the hospital staff and
16 whether or not there was some
17 concern -- should be concern on the
18 Nurse Practice Act. That was sent
19 to Mr. Wronski. So I leave that to
20 you or to Dr. Dailey and new
21 business to bring up and discuss.
22 I want to go one step out of
23 order and I'd like to ask for the
24 EMS staff report first at this time.

1 Mr. Wronski.
2 MR. WRONSKI: Thank you,
3 Dr. Henry. I have a few items.
4 Just a quick review of the budget.
5 As all of you know, the last time
6 and probably the time before that, I
7 reported on a rather bleak picture
8 for the State budget. That has not
9 changed. The Governor's budget is
10 expected out soon, I believe, within
11 the next week or so. I think it's
12 the middle of December is their
13 goal. That's earlier than normal,
14 and I believe that is so that people
15 will have more time in the
16 Legislature to react to it and they
17 can come to some agreement, because
18 my anticipation is that there will
19 be quite a few items in the budget
20 which will be cut from last year,
21 either cut totally or limited in the
22 amount of payment.
23 Now, what does this mean for
24 EMS? I haven't seen the Governor's

1 budget, so I can't tell you
2 specifically what it will say, but
3 my understanding at this point is
4 that the EMS account, you know, is
5 one of those types of accounts that
6 will remain whole. But again, you
7 have to wait until the budget is out
8 to find your page and see the number
9 on it, so I'm going to look for that
10 first thing. Again, I don't
11 anticipate any change. Definitely
12 there won't be any increase. What I
13 do suggest, is that all of you who
14 receive funding from the State for
15 other reasons to run your EMS
16 systems, is you pay attention to the
17 budget because potentially there
18 could be changes there, because
19 there is a huge deficit, and they
20 have to find ways to limit state
21 spending.
22 In regard to simpler ways to
23 limit state spending, and that's
24 state staff, and meetings, et

1 cetera, we have a meeting in
2 January. All council liaisons are
3 being asked to attend the meeting in
4 January which will go through the
5 final rules and processes for
6 councils. That will apply to all
7 councils, but my anticipation is
8 that meeting will also discuss cost,
9 and funding, and meetings, and what
10 they're going to expect. And what I
11 expect is that there will be some
12 directives to try to hold some
13 meetings electronically. If you can
14 save that, cut down on meetings, and
15 they'll look -- be looking clearly
16 for meetings that are statutorily
17 required. This body is statutorily
18 required to meet. How often we meet
19 is always open to discussion, and we
20 may need to do that at some point
21 during the year depending how the
22 budget looks.
23 On a simpler account, travel
24 is limited. State staff have

1 limited overnights that we're
2 allowed to use. It has to be
3 critical business. For state
4 council members and SEMAC members,
5 when you travel you need to look at
6 what your anticipated cost will be
7 to attend the meeting. If it's
8 going to be $500 or more, we need
9 pre-approval for that. I believe
10 that rule is going to stay in place
11 for some time. I don't think
12 there's too many instances where
13 we'll go over the 500, but there are
14 some, so you need to think about
15 that if you're coming in and it
16 looks like your bill will be over
17 500. It doesn't mean that won't be
18 approved but we have to have it
19 reviewed and give an argument why we
20 need to expend that cost.
21 A handful of items. I will be
22 having a meeting with Dr. Funk and
23 others tomorrow at the end of the
24 state council meeting, or

1 potentially sooner, just to go over
2 some issues that have been on the
3 table for awhile regarding the
4 ability of EMS personnel to get
5 training within a hospital setting,
6 and we're going to meet on that.
7 I've got a commitment from Hospital
8 Services to participate in a later
9 meeting, but this current one will
10 be to set some goals when we meet
11 with Hospital Services and
12 potentially in the near future set
13 up a meeting with State Education to
14 try to get their either support or,
15 at least, that we understand their
16 position if we don't get their
17 support regarding this issue. And
18 so I've agreed that, you know, we'll
19 move this process along. And I do
20 have commitment from Hospital
21 Services who -- their new director,
22 by the way, is Mary Ellen Hennessey.
23 She has just recently been
24 appointed, and she has agreed to

1 work with us on this.
2 The membership and diversity;
3 some members have asked me about
4 that, just to go over that again.
5 We have made some progress in
6 getting members who have waited for
7 the vetting to be completed --
8 completed, or near completed.
9 Dr. Goodman is now able to vote.
10 Dr. Davidoff should be shortly;
11 although, I don't have the final
12 letter, but he has gone through the
13 process and is still speaking to me,
14 so that's a good thing, and he's
15 here, and I thanked him for that,
16 and I thank him again. We will try
17 to move along the rest of the
18 membership as quickly as we can.
19 I'm having regular conversations
20 again with the liaison to the
21 Governor's office about this and how
22 we can move vetting along.
23 I do want to let all of you
24 know about a serious situation. On

1 November 1, Arnott Ogden Medical
2 Center ceased being a trauma center,
3 and the reason they ceased being a
4 trauma center is they were unable to
5 staff surgical coverage for the
6 trauma program. Now, it doesn't
7 mean they don't have surgical
8 coverage in the hospital, but they
9 did not have trauma surgical
10 coverage. And this is an unusual
11 one. Typically, when we've had an
12 area center have issues regarding
13 staff coverage, it has been one of
14 the ancillary supportive surgical
15 groups, but this was actually the
16 core of any trauma program, and it's
17 your trauma surgeons. And they were
18 unable after the -- I believe the
19 retirement over there at chief to
20 maintain enough surgeons to assure
21 coverage, so as of November 1 they
22 are no longer a trauma center. The
23 positive part is that, with the help
24 of the Chairman of the State Trauma

1 Advisory Committee, Strong Memorial
2 Hospital has stepped up to the plate
3 and is working with Arnott Ogden to
4 identify, if they can, surgeons who
5 might come in and work with Arnott
6 Ogden and make the coverage. My
7 understanding is there have been
8 some positive results with that, why
9 we don't have surgical coverage to
10 reopen the hospital yet. They have
11 had some positive replies that they
12 are looking at. And so I'm hoping
13 that over the next couple of months
14 Arnott Ogden is back in place. The
15 key for everybody -- and I don't
16 have the map here. I brought it to
17 the State Trauma group -- is that if
18 you look at the State, once Arnott
19 Ogden closed its doors we did not
20 have a state trauma center south of
21 Binghamton, through the entire
22 southern tier because the WCA
23 Hospital in Jamestown, the corner of
24 the state, used to be an area

1 center, but they closed, through the
2 staffing problems, about two years,
3 as a trauma center, not a hospital.
4 So there are no trauma services in
5 the State in that whole southern
6 tier. And at present they work out
7 transfers to other -- to the
8 regional centers or, in some cases,
9 they move them across the border to
10 Pennsylvania centers when needed,
11 and that is a patient-by-patient
12 decision. So, you know, the issue
13 of staffing is critical. You know,
14 in your own hospitals, you have to
15 pay attention to that. And what I
16 would ask you to do, is if you -- if
17 it was your understanding that your
18 hospital, who may be a trauma
19 center, is having difficulty is let
20 us know early. We can do what we
21 can to reach out and see if we can
22 get you some help, but we're hoping
23 Arnott gets back online in the next
24 few months.

1 I don't know if I mentioned
2 last time that we won a Governor's
3 Highway Safety Grant to build a
4 platform for the State in accepting
5 data. What we're going to be doing
6 during this grant period is
7 evaluating the State's capability
8 in, you know, agency-by-agency to
9 collect and give us electronic data.
10 You know, we're also going to work
11 with a contractor to develop a
12 potential system to collect that
13 data and ultimately analyze it.
14 It's not a grant that will pay for
15 the implementation of electronic
16 data, but it will help us at the
17 receiving end collect from people
18 who, in fact, are setting up
19 systems.
20 Is there anything else you
21 want to mention on that?
22 The last thing to mention is
23 capnography, and that will come up
24 in Medical Standards as well. We

1 had a long discussion at the Medical
2 Standards Protocol Committee, but
3 the Commissioner has the capnography
4 advisory. He did not receive it
5 until just recently because the
6 Division of Legal Affairs reviewed
7 the original document, made some
8 minor modifications to it, but did
9 advise me that one major thing in
10 the advisory is that the advisory
11 can't mandate that the services
12 purchase the capnography device.
13 However, the advisory can stand on
14 its face as establishing a standard
15 of care. And that, in and of
16 itself, is a very powerful document.
17 So that's with the Commissioner, and
18 I expect he'll get to review that
19 and give me his comments or okay to
20 release it in the next couple of
21 weeks. But again, as I said, it had
22 been in legal review for a couple of
23 weeks and we had to modify some of
24 it.

1 The last thing -- well, not
2 quite the last thing, for next year
3 we do have confirmation on our
4 meeting dates and where we're going
5 to meet. We're going to be meeting
6 at the Crown Plaza at State and
7 Lodge Street, downtown Albany, and
8 the meeting dates will be February
9 17 and 18, June 9 and 10, September
10 8 and 9, and December 1 and 2. So
11 again, that's downtown Albany at the
12 Crown Plaza.
13 Now, the last thing I want to
14 mention is both a happy and a sad
15 event. Sometime in your career all
16 of you have had someone you've
17 worked with very closely who has
18 really supported you and supported
19 your work. What I'd like to
20 announce, and this is a good thing,
21 is Marjorie Geiger has accepted a
22 position, and she's been appointed
23 by the Governor's Office as Director
24 of the Office of Patient Safety, and

1 that confirmation just came through.
2 She will be accepting -- she has
3 accepted that position. She'd be
4 crazy not to. It's a loss for us.
5 Marjorie has agreed to periodically
6 call me up and tell me it's okay;
7 things will get better. And she's
8 going to send me all of her files
9 since I don't keep any, but it has
10 been a distinct pleasure having
11 Marjorie work as my partner, and I
12 appreciate that. But I would like
13 to thank her.
14 MS. GEIGER: Thank you,
15 Ed. It has also been a privilege
16 and a pleasure to work with you and
17 all my colleagues in the Bureau of
18 EMS, and it has also been a real
19 honor to partner with the State
20 Emergency Medical Advisory Committee
21 all these years. I think that you
22 folks in this room and your
23 predecessors have achieved a great
24 success in moving the prehospital

1 care system forward, and you're to
2 be commended to that. You've done
3 it without gratuity, I should say,
4 but with a lot of gratitude, and
5 keep up the good work.
6 MR. WRONSKI: Dr. Henry.
7 DR. HENRY: Marjorie, I
8 would say I think I'm a little taken
9 back about the timing of the
10 announcement. We're happy for you.
11 I don't think I could think of
12 anyone better to be head of Patient
13 Safety in New York. And I would
14 say, from our perspective, you've
15 brought incredible intellect and
16 integrity to the position you have
17 and your ability to network with
18 others within the Department and
19 outside the Department has furthered
20 the cause, and we'll miss you a lot,
21 and we wish you the best in your new
22 position.
23 MR. WRONSKI: Questions?
24 MR. ZEEK: Yes. Is there

1 an update on the blood transfusion
2 situation?
3 MR. WRONSKI: Yeah. Lee
4 Burns has been regularly working
5 with Dr. Lyndon's office in getting
6 them information so that they can
7 move along the regulation on blood
8 transfusion. It has not -- it's not
9 finalized yet. It hasn't been
10 published. There has been work that
11 that office has been doing on not
12 just the protocol language but the
13 training curriculum. Our guess is
14 that they'll be done with that soon,
15 but we have had regular
16 communications ongoing, so it's not
17 a dead process, but it is taking a
18 while to get finalized.
19 MR. ZEEK: It has seemed
20 pretty quiet on that front. I just
21 was curious.
22 MR. WRONSKI: Yeah, it
23 hasn't been quiet, but it hasn't
24 been public. It has been behind the

1 scenes.
2 MR. ZEEK: Thank you.
3 DR. HENRY: I'd like to
4 move along then and go to the
5 Education Committee report.
6 Dr. McEvoy.
7 DR. MCEVOY: We are going
8 to bring one seconded motion
9 forward. I might as well do that
10 first. Basically, we reviewed the
11 FDNY Rescue Medic Training Program
12 and agreed -- the motion actually
13 reads to accept the FDNY Rescue
14 Medical Training program with minor
15 terminology changes and the addition
16 of an objective covering transport
17 and fusion pump failure. I think --
18 does that get voted on here as well
19 as tomorrow? I believe it does.
20 DR. HENRY: It would get
21 voted on tomorrow for sure, and we
22 heard briefly about this at the
23 Medical Standards meeting, and we
24 knew it was being referred to

1 Education.

2 DR. MARSHALL: Yeah, so we

3 were -- Medical Standards actually

4 approved the actual protocols. We

5 are waiting for approval of the

6 curriculum and other wording from

7 Education. So now that we've done

8 that, that can move forward.

9 DR. MCEVOY: Dr. Kaufman

10 came to our meeting, and basically

11 he's going to carry back that

12 information to Dr. Gonzales.

13 DR. HENRY: Good. So, I

14 think it could probably be all voted

15 on tomorrow.

16 DR. MCEVOY: Okay.

17 DR. HENRY: If members

18 feel they want to vote on it here,

19 that's fine. They'll know that it's

20 required.

21 DR. MCEVOY: The other

22 discussion was, we're continuing to

23 do some work on marrying the new

24 curriculum at all levels to the

1 current curricula that exists in New
2 York State. That's an ongoing
3 process. There is no urgency to it
4 because none of that curricula has
5 actually reached the textbook level
6 at this point, so we should arrive
7 at that point at about the time that
8 the materials are available to teach
9 it with.
10 There was some lengthy
11 discussion about the contract with
12 the Bureau and the written exam
13 provider. It had to go out to be
14 rebid. The bids are due back again
15 to the Bureau December 5, which puts
16 into question whether they'll be
17 able to administer the written exams
18 in January. They've asked the
19 Comptroller's office to give an
20 extension to the current contracts
21 for three months which would allow
22 that to take place. Whether or not
23 that's going to be approved and
24 whether or not the new bids would be

1 expedited to a degree that they
2 could understand whether that exams
3 can be given in January remains to
4 be seen. But the Bureau plans to
5 make a decision on that on December
6 8 so people who need to test at that
7 point will find out whether they'll
8 have an exam or not, which is all
9 right for people whose cards expire
10 in January, or thereafter, because
11 they'll get an extension until
12 March. It would create some
13 hardship though, considerably, for
14 people who are taking original
15 courses or whose cards expire prior
16 to January. And certainly the
17 Commissioner is aware of that and
18 has spoken with the Comptroller's
19 office, so hopefully that those
20 glitches will get resolved prior to
21 December 8.
22 Then I think the last item of
23 note from the Committee is just some
24 recognition that the Chairman of

1 Education and Training, Deb Fults
2 Jones, is finishing her five years
3 as chairing that committee. She
4 probably mistakenly believes that
5 her replacement will be vetted
6 shortly, but we did recognize her
7 for five years of service chairing
8 the Education and Training. Thank
9 you.
10 DR. HENRY: Let me echo
11 that on our behalf. I think you've
12 done a great job. Are there any
13 questions for Dr. McEvoy? Hearing
14 none, we'll move to Medical
15 Standards. Dr. Marshall.
16 DR. MARSHALL: Thank you.
17 Medical Standards met earlier today,
18 and we have the following protocols
19 come forward as seconded motions.
20 The first one was Western New York.
21 They had a presentation on post
22 cardiac arrest hypothermia which
23 we've discussed before and presented
24 a protocol that was approved. I

1 don't have the flow sheet in front
2 of me. But, basically, patients who
3 are post arrest in the field to have
4 return of spontaneous circulation
5 will begin the cooling process in
6 the field. And as Dr. Dailey had
7 pointed out earlier, it's not really
8 therapeutic hypothermia, but it is
9 just the beginning of the process
10 that will be taking place in the
11 prehospital setting. The protocol
12 includes identification of
13 appropriate patients excluding those
14 who are in traumatic arrest and
15 those who are obviously pregnant.
16 There was some discussion of some
17 systems that are now looking at
18 trauma patients, post arrest trauma
19 patients that have return of
20 spontaneous circulation who may,
21 sometime in the future, fit into
22 this protocol but not at the present
23 time.
24 Essentially, in the

1 prehospital setting, those patients
2 who fit into the protocol who have
3 returned spontaneous circulation
4 will begin the cooling process with
5 ice packs and cooled saline. The
6 Western Region has actually gotten a
7 grant to provide, I believe, 15
8 cooling units for ambulances so that
9 the ambulances will have the ability
10 to have cooled saline available for
11 these patients. They'll be
12 distributed around the region in
13 various ambulance services.
14 The protocol was approved
15 unanimously. We have discussed this
16 before. There was some discussion
17 about whether or not hospitals had
18 the ability to continue the cooling
19 process once in the hospital. There
20 are apparently approximately four
21 hospitals that currently have the
22 ability and are looking into
23 continuing this process in the
24 hospital setting. We did have some

1 discussion about EMS's role in
2 telling the hospital whether or not
3 they should have this process, but
4 this process will begin in the
5 prehospital setting. There will be
6 a QA process that goes along with
7 this protocol and we would be
8 expecting to get data back in the
9 future on it, and that comes
10 forwarded as a seconded motion.
11 DR. HENRY: Would anyone
12 want to see the protocol or want to
13 see the flow sheet? Because we
14 should be able to produce that,
15 certainly on paper if you want to
16 see a copy. Dr. Davidoff.
17 DR. DAVIDOFF: I have not
18 seen a copy of it, but I was led to
19 believe that the protocol included
20 the use of Valium to prevent or
21 diminish shivering?
22 DR. MARSHALL: Yes.
23 DR. DAVIDOFF: Was there
24 any discussion regarding using a

1 paralytic even though paralytics are
2 not allowed in that region for use
3 unless there is a second paramedic I
4 believe. But for use under this
5 protocol, to get some better
6 evidence, was there a discussion
7 about using a paralytic?
8 DR. MARSHALL: There was
9 discussion about use of paralytics.
10 Right now there are only two
11 agencies in that region that have
12 paramedics that are capable of doing
13 RSI. That's why they stuck with
14 Valium in this protocol. There was
15 some discussion.
16 DR. DAVIDOFF: Would the
17 use of a paralytic in this
18 particular setting constitute RSI?
19 Only because I'm afraid that ten
20 milligrams of Valium may not truly
21 diminish the shivering response, in
22 which case we're really not going to
23 get these patients cooled properly.
24 DR. MARSHALL: Well, I

1 think that part of the discussion
2 was that in the prehospital setting,
3 you're just beginning the process.
4 So if they start shivering, give
5 them some Valium and decrease the
6 shivering. It may not stop it, but
7 you're not actually going to get
8 them to a therapeutic temperature in
9 the prehospital setting, so this was
10 just the start of the process. So I
11 believe that it wasn't really felt
12 from the group that they needed to
13 go further and have paralytics,
14 especially since in the region they
15 only have two services that are
16 potentially capable of giving that
17 treatment at this time.
18 DR. HENRY: So let me
19 refer you to the screen if you want
20 to see the protocol in an
21 algorithm-type form. There is the
22 top half. So you can see there,
23 Dr. Davidoff, that after the cold
24 saline begins, Diazepam is an option

1 if shivering begins. Okay? I don't
2 know if others -- I don't know you
3 saw the protocol. You didn't -- you
4 saw it, okay. Dr. Goodman.
5 DR. GOODMAN: What's
6 typical transport times in this
7 region?
8 DR. COOLEY: Dr. Cooley
9 from the region, the REMAC chair.
10 The way this is rolling out right
11 now, it's going to be more than
12 likely, primarily, in the urban and
13 suburban arena around Buffalo. The
14 more distant hospitals will have to
15 have involvement on an ED level,
16 which there has been a lot of
17 encouraging discussions, and they
18 want to be involved. And a lot of
19 those critical patients that do have
20 the resuscitation, typically are
21 transferred into Buffalo anyway.
22 Typical transport time is going to
23 be ten to fifteen minutes at most in
24 the city itself.

1 DR. GOODMAN: That sounds
2 reasonable. My concerns would be
3 for those areas in which the
4 transport times are longer.
5 Although, I think the literature is
6 fairly compelling for therapeutic
7 hypothermia. Is it -- how do you
8 know when you reach your end point
9 by using tympanic temperature
10 monitoring? You know, we discussed
11 in the rehab setting; it's probably
12 not the best way to measure
13 temperatures. And then when you
14 reach that end point, how do you
15 stop it? You know, ice packs may or
16 may not be -- it's probably not the
17 best way to maintain that
18 temperature or get back to where you
19 want to be if you have gone beyond
20 what your end point is.
21 DR. COOLEY: Right. And
22 again we don't anticipate them --
23 well, although, it does get cold up
24 there -- reaching therapeutic

1 levels, you know, in transit.
2 Clearly, emergency departments have
3 participated in this program and
4 will need to be a little more
5 involved and obviously have more
6 invasive measuring capabilities.
7 There was some discussion about the
8 potential for esophageal measuring
9 but that's -- we're trying to both
10 keep this cost effective and, you
11 know, simple to use at this point
12 and see where we go.
13 DR. HENRY: Any other
14 questions? Okay, hearing none -- go
15 ahead, Dr. Marshall.
16 DR. MARSHALL: That was
17 the first one that comes up for a
18 vote, the seconded motion.
19 DR. HENRY: All right, so
20 all in favor of the motion for this
21 protocol for hypothermia in this
22 region raise your hands. All right,
23 do you want to do a roll call?
24 We'll take a roll call vote. Go

1 ahead.
2 (Roll call vote was taken.)
3 DR. HENRY: Thank you, it
4 passes. Dr. Marshall.
5 DR. MARSHALL: Thank you.
6 The next set of protocols are the
7 Susquehanna ALS protocols, and these
8 also come forward as a seconded
9 motion with the following
10 recommendations. During discussion,
11 there was clarifications in the
12 skills at the EMT-I level. There
13 was some dosage clarifications, some
14 discussion of the informed consent
15 protocol that they have in their
16 region which has been in place, so
17 that's not a change, so that's not
18 up for a vote. But in the new
19 protocol there was a discussion
20 about the meconium aspiration in the
21 neonatal patients, and that was to
22 come out. The recommendation is not
23 to aspirate unless there is
24 meconium; is that correct?

1 MS. CHIUMENTO: Unless
2 there is respiratory distress.
3 DR. MARSHALL: Unless they
4 have respiratory distress.
5 MS. CHIUMENTO: They don't
6 intubate or --
7 SPEAKER: No intubation.
8 MS. CHIUMENTO: No
9 intubation. They can oral suction
10 --
11 DR. MARSHALL: There was
12 also some discussion of their
13 interfacility transports. Different
14 agencies that do interfacility
15 transports have interfacility
16 protocols that are all brought
17 forward and approved at the REMAC,
18 so that was approved. That was part
19 of their protocols. Those were
20 the -- that was a -- that comes
21 forward as a seconded motion.
22 DR. HENRY: Okay, any
23 discussion or questions? We'll take
24 a vote on that.

1 (Roll call vote was taken.)
2 DR. HENRY: Okay, it
3 passes. Thank you.
4 DR. MARSHALL: The next
5 protocol was Westchester.
6 Westchester ALS protocols were
7 brought forward. There was some
8 discussion about complying with the
9 American Heart Association standards
10 that this body recommended
11 previously. In that event there
12 were some typos in the Westchester
13 protocol which still listed
14 endotracheal tube drug
15 administration which will be
16 corrected. There was one
17 administration of Narcan for
18 neonates via nasal spray, and that's
19 going to be removed because there
20 was no evidence of that being
21 efficacious.
22 We also discussed the use of
23 procainamide in one of their
24 protocols. Procainamide remains in

1 their protocol. So the discussion
2 came up, if we're going to recommend
3 compliance with the American Heart
4 Association guidelines, is it still
5 permissible for regions to include
6 other things? And the general
7 discussion was, yes, regions can
8 include other things as long as they
9 have a basis for doing it, a medical
10 basis and not just because something
11 is available on the ambulance or
12 because we're accustomed to it or
13 we're used to it, as the reason for
14 having it. So, in that light, I
15 think procainamide was left in the
16 protocol, but it was changed to a
17 medical control option under one of
18 their arrest protocols. And that
19 comes forward as a seconded motion.
20 DR. HENRY: All right, any
21 discussion or questions? We'll take
22 a vote on that.
23 (Roll call vote was taken.)
24 DR. HENRY: Thank you.

1 Dr. Marshall.

2 DR. MARSHALL: One more, I
3 think. New York City ALS protocol
4 change. New York City has put in
5 place a program burn transport. In
6 the event of a major burn MCI, and
7 this is put together by the New York
8 State Department of Health, the New
9 York City Department of Health and
10 Mental Hygiene, the Office of
11 Emergency Management and other
12 groups. And New York City has
13 divided its hospitals. I believe
14 there are 60 or so hospitals that
15 have been divided into tiers, so
16 tier -- you have the burn centers
17 that we have which would be tier 1.
18 Dr. Kaufman is here. He can correct
19 me if I misspeak. Tier 2 would be
20 all the trauma centers in New York
21 City, and tier 3 hospitals would be
22 other hospitals in New York City.
23 These hospitals would be designated
24 to receive burn patients in the

1 event of a major burn disaster --
2 meaning that there's a large number
3 of patients with significant burns
4 due to an explosion or other
5 incident.
6 The changes in the New York
7 City protocols will allow
8 transportation -- it's basically a
9 transportation protocol -- will
10 allow transportation of these
11 protocols to these other centers,
12 these other tiered centers. Each of
13 the tiered centers have received, in
14 preparation for this program, a burn
15 disaster cart which contains enough
16 medical supplies for the treatment
17 of, I believe, ten patients for
18 three days, or something like that.
19 In addition to that, the plan --
20 there's other parts of the plan that
21 don't involve changes in this
22 protocol that involve the Department
23 of Health. Maybe Mr. Wronski can
24 speak to that. It also involves

1 transport of patients, secondary
2 transport of patients from these
3 second and third tier hospitals to
4 other burn hospitals around the
5 state and in other -- possibly in
6 other states also. So it's part of
7 a larger program. It's just not New
8 York City, but we needed to change
9 our transportation protocols in New
10 York City to allow direct transport
11 essentially from the scene to these
12 other non-burn center hospitals.
13 DR. HENRY: Okay, good.
14 Any questions for Dr. Kaufman or
15 others on that? All right, we'll
16 take a vote.
17 (Roll call vote was taken.)
18 DR. HENRY: All right,
19 thank you. Do you have anything
20 else, Dr. Marshall?
21 DR. MARSHALL: Just one.
22 For information purposes, there was
23 some discussion two meetings ago, I
24 believe, regarding online medical

1 control and the use of M.D.'s or
2 mid-level practitioners to provide
3 online level medical control to
4 paramedics in the field. The
5 current statutory language reads
6 that online medical control is the
7 advice and direction provided by an
8 M.D. or under the direction of an
9 M.D. So the statutory language does
10 allow for options. So what we've
11 done is put together a small group
12 to look at the options and bring
13 back something for discussion to
14 look at the different options that
15 might be available for different
16 regions in terms of the ability and
17 the availability of online medical
18 control.
19 DR. HENRY: All right,
20 good. Any further discussion or
21 questions? Okay. Hearing none, I'd
22 like to move to the Evaluation
23 Committee's report, QI/QA quality
24 improvement, quality assurance.

1 Mr. Delagi and Dr. Kaufman.
2 MR. DELAGI: Thanks,
3 Dr. Henry. Just beginning, on
4 behalf of the Evaluation Committee,
5 I just want to extend our thanks to
6 Marjorie for all the fine work that
7 she gave us as our staff member
8 assigned to our committee and
9 congratulate you on your new
10 position, and you certainly will be
11 missed by our committee.
12 We had our meeting earlier
13 today. There are no seconded
14 motions to bring forward. Our
15 meeting was opened up with a
16 presentation by Brian Gallagher from
17 the School of Public Health who put
18 together a very nice summary
19 presentation of the 2006 PCR data.
20 And it was pointed out that this is
21 a hallmark year for two reasons.
22 The first one is that it includes
23 New York City data from the FDNY and
24 adds over a million cases to the

1 database. And secondly, this will
2 be the first year where the
3 out-of-hospital data is combined
4 with in-hospital data provided by
5 the SPARCS database.
6 So just in very brief summary,
7 we reviewed a report that had
8 2,368,992 records in it, and the
9 analysis includes the type of call,
10 the call disposition, the primary
11 presenting problem, gender, mean
12 response times and comparisons in
13 volume, either increases or
14 decreases in volume, over the 2002
15 to 2006 time period.
16 We expect the 2006 data discs
17 to be released to the regions
18 shortly, and sometime in 2009 we
19 anticipate a report which will
20 include the commingling of that
21 out-of-hospital data with the
22 in-hospital SPARCS database. And
23 we're excited to see what the
24 comparison of presenting trauma with

1 outcome data looks like, as that
2 will be real useful to us going
3 forward.
4 During the staff report we did
5 learn about the awarding of the
6 Governor's Traffic Safety Board
7 Grant, and we're very pleased to
8 hear that, as it relates to two
9 items that have been ongoing for our
10 committee. The first one is working
11 towards NEMSIS compliance as a
12 state, and the second one is
13 establishing a portal for electronic
14 data receipt across the state. As
15 you recall, those were two
16 initiatives that were near and dear
17 to the Committee's heart; something
18 we've been working on very, very
19 diligently on over the last year or
20 two, and are pleased to hear about
21 that.
22 We learned that the second
23 pediatric trauma report is under
24 development, and the preliminary

1 report on the recent pediatric
2 capability survey that was completed
3 not too long ago will be given -- we
4 anticipate that coming out tomorrow
5 --
6 MS. GEIGER: Yes.
7 MR. DELAGI: -- at State
8 Council?
9 MS. GEIGER: In EMS-C.
10 MR. DELAGI: In the EMS-C
11 report, thank you.
12 We learned that the Bureau and
13 the Department is working with the
14 New York Agriculture Health Center
15 by using PCR data from ten rural
16 counties to investigate farm-related
17 occurrences, with the goal to
18 enhance the epidemiologic study of
19 farm-related injuries and its
20 impact -- and having an impact on,
21 perhaps, generating prevention
22 strategies in that community.
23 You may recall some time ago,
24 actually going back to the January

1 meeting, the Evaluation Committee
2 partnered with the Air Medical TAG
3 to take a look at some data that was
4 being collected on air medical
5 services utilization. A report was
6 put together and has been
7 distributed for your review.
8 Just to briefly summarize for
9 you a couple of salient points. The
10 first one is that this was a survey
11 to determine inclusion criteria for
12 air medical requests based on the
13 ground crew's perception of getting
14 the patient to a closer hospital in
15 a quicker amount of time -- I'm
16 sorry, a specialty hospital in a
17 quicker amount of time, providing a
18 response by air medical service
19 providers that had additional
20 procedures or medications available
21 to them and to judge whether or not
22 those requests were consistent based
23 on the criteria outlined in policy
24 statement 0505.

1 And just zipping right through
2 to the conclusions, based on the
3 data, given the limitations that we
4 cited in the report, it certainly
5 does suggest it's reasonable to
6 conclude that utilization of AMS
7 appropriateness in New York State is
8 indeed consistent with the published
9 criteria for reducing transport
10 times to a hospital capable of
11 providing definitive care, or when
12 physical findings indicative of
13 traumatic injury are present, and
14 that the percentage of AMS requests
15 during the study period for medical
16 calls or not consistent with the
17 policy is very, very low. And I
18 hope you've all had a chance to look
19 at it real quick. I'll be happy to
20 answer any questions, if I can.
21 DR. HENRY: I have one
22 question. When you number the
23 statewide totals for factors such as
24 adult major trauma, can people

have -- can one patient have more
than one criteria?

MR. DELAGI: Absolutely.
We found that consistently across
the board, that in virtually every
data tool that was submitted, out of
the 513 flights that were logged in,
virtually every one of them had at
least one or two situational
criteria and at least one or two
anatomical physiologic criteria.
Again, indicating that helicopters
are being requested for multiply
traumatized patients. You'll see in
there also -- I know it's a little
bit beyond the scope of your
question -- that abnormal Glasgow
Coma Scale emerged as the single
most popular? -- if that's the right
word -- factor in using air medical
requests.

DR. HENRY: Any other?
Dr. Funk.

DR. FUNK: Thanks, Bob,

1 and the entire Evaluation Committee
2 for seeing this through. It was a
3 big project. And while he says it
4 was a cooperative effort, the air
5 medical group did put a little bit
6 of effort into it, a little bit.
7 Your group really did a lot of work
8 on this, and the final product here
9 looks great. I'd like for us to
10 take this and do something with it.
11 One of the things that we looked at,
12 when we talked about gathering all
13 of this data, was, you know, we
14 wanted to see if the people in our
15 helicopters were sick. They are.
16 They meet the criteria that we set
17 forward with a five percent
18 inappropriate utilization rate,
19 which is pretty darn low. If you
20 consider that to be the over triage
21 rate? How many of our trauma
22 centers think that they have a five
23 percent inappropriate utilization
24 rate? We don't. We have 30 to 50

1 percent, and that's what ACS
2 accepts. So I think that we've
3 shown -- it's a limited study,
4 certainly, but we've shown that the
5 patients in our helicopters are
6 sick. Now what do we do with that
7 data? Should those patients that
8 we've proven are sick go to certain
9 hospitals? Should they go to Level
10 1 hospitals, if it's appropriate to
11 go to those Level 1 hospitals?
12 Since our data in New York State
13 shows that our patients with certain
14 injuries, the injuries that are
15 evidenced in these patients, do
16 better at Level 1 hospitals. We're
17 talking about a relatively small
18 number of patients, but we want to
19 be sure that those patients get the
20 best care. So, should we take this
21 data and perhaps draw that
22 conclusion from it? I think that
23 what we probably need to do is go to
24 the Trauma Advisory Committees and

1 ask for their input on these
2 patients and look at the patients,
3 the 20 percent of patients that went
4 to Level 2 centers. What happened
5 to them? Did they then get
6 secondarily transferred out? What
7 were their outcomes when compared
8 with the outcomes of the patients at
9 the Level 1 centers? Nobody is
10 going to suggest that hospitals are
11 not doing the best that they can for
12 patients, certainly. And we've
13 heard already about trauma centers
14 who are not able to stay open
15 because of staffing or numbers or
16 things like that, but we want to --
17 if we have the ability to make
18 decisions in the field that are
19 going to improve patient care and
20 patient outcome, we want to be able
21 to do that. We did the survey.
22 Let's go and look at what happened
23 to the patients that went to the
24 Level 2 centers and if we're making

1 the best decisions for them with our
2 destination criteria when we put
3 them in the back of the helicopter.
4 DR. HENRY: Okay, thank
5 you. Dr. Goodman.
6 DR. GOODMAN: I hear what
7 you're saying, but I'm not sure what
8 to do with it, or this data. For
9 one thing, I think it's important we
10 realize it is geographically
11 specific. But what I haven't heard
12 is, if you get to a hospital quicker
13 by helicopter, does that translate
14 to improved decreased mortality?
15 And if that same patient got to the
16 same place ten minutes later by
17 ground, perhaps more safely, what we
18 see is the alarming number of
19 helicopter incidents over the last
20 year, is there any detriment?
21 Helicopters are an extremely
22 expensive means of travel; although,
23 your study only saw a 5 percent
24 over-utilization, I think that that

1 would be very different in certainly
2 other communities. But if that same
3 patient went by ground to the
4 hospital, would there be a
5 difference in that outcome? And I
6 think that's ultimately what we need
7 to look at. Not saying that they
8 shouldn't be at that Level 1 center.
9 I'm questioning whether they need to
10 go by air to the Level 1 center.
11 DR. FUNK: I think that it
12 would be difficult to do that study
13 in a community that is already
14 considering helicopters to be the
15 standard of care for certain patient
16 populations. There are nationally
17 some studies that do a before and
18 after kind of, you know -- the
19 experiments that were forced by
20 helicopters going out of service or
21 out of business or the before and
22 after -- before they had a
23 helicopter and then they had a
24 helicopter and they compared

1 outcomes. There are several studies
2 that are out there nationally that
3 talk about the benefits that
4 helicopters offer and trauma is one
5 of the biggest ones. There are
6 certain criteria. You have to be
7 hurt. Your car can't be hurt. You
8 have to be hurt. And that's why
9 we've really focused on these
10 physiologic criteria. We don't have
11 a study like that in New York State,
12 and I think it would be hard to do.
13 I would hesitate to go to a
14 community and say, you don't get to
15 have a helicopter because we want to
16 study how you do by ground. Dr.
17 Dailey, I'm sure, would be quick to
18 point out that one of the things
19 that we do need to look at, and
20 probably within each region, is
21 where are these helicopters being
22 used, and is it really appropriate
23 if you can see the hospital from the
24 accident scene to sit there and wait

1 for a helicopter? And most of us,
2 including air medical directors,
3 would say it's probably not
4 appropriate to do that, but that is
5 really something that I think each
6 region really needs to look at and
7 perhaps use the same data tool and
8 add time criteria into it and then
9 go back and look at it. Because
10 frankly, we've all been at the
11 trauma center when the family
12 arrives from the accident scene
13 before the helicopter does. And,
14 you know, who are we serving by
15 doing that? We do need to look at
16 this further, I agree, but in terms
17 of looking at once you're in a
18 helicopter, where you go, I think
19 that we need to look at that, and we
20 can by using this data, getting
21 together with the folks who have
22 access to the trauma registry.
23 DR. HENRY: Mr. Wronski.
24 MR. WRONSKI: Yeah, I

1 appreciate this report. It's
2 important that we show that we're
3 constantly looking at our air
4 medical system, given the
5 information about nationally and in
6 this state, you know, in the last
7 decade, the loss of life. So when
8 we put a crew up in the air and we
9 put a patient in there, we want to
10 make sure that that makes sense
11 medically and otherwise. I think
12 everyone will agree what we don't
13 have is certain missing pieces of
14 the puzzle, as Dr. Goodman has
15 pointed out, and I think Dr. Funk
16 will agree. You know, things that I
17 think we need to look at is can we
18 match up the helicopter data to the
19 hospital data? Can we do some
20 simple things, such as if a
21 helicopter delivers a patient, a 911
22 case, to a hospital does that
23 patient walk out of the ED that day,
24 were they admitted and cared for?

1 One of the things I've heard
2 anecdotally, and not as a system
3 regularity, was a couple of patients
4 who were delivered by helicopter and
5 were released the same day. So the
6 question there, of course, is, you
7 know, why did we need a helicopter?
8 Well, you know what? Sometimes it
9 might turn out that in EMS that was
10 the right call, but I don't know
11 because, you know, we haven't seen
12 those cases. But I think those are
13 the kinds of things we have to do.
14 On top of this report is marry it to
15 the hospital data and take a look at
16 that, both from the utilization
17 point of view and from a -- does
18 this benefit the patient's overall
19 care? I think we'll find that there
20 are some patients who it really does
21 benefit, and then we'll find there
22 is another category of patients who
23 we thought it benefited and it
24 doesn't. We have found that out in

1 trauma, as we've spent more than a
2 decade going through the trauma
3 registry data. And while we thought
4 a trauma center might benefit all
5 major trauma, it really has a more
6 distinct benefit, certain types of
7 major trauma over and above others.
8 So the more and more you look at it,
9 you can drill down into your patient
10 base. And so this is a great
11 report. I think it's Report 1, and
12 I think we can keep moving on this
13 as we can get our hands on more
14 information, particularly the
15 hospital information that's married
16 to this.
17 DR. HENRY: Dr. Van
18 Roekens.
19 MR. VAN ROEKENS: Yeah. I
20 agree with all the comments, and I
21 guess I'd like Dr. Funk just to
22 comment on the Level 2, only 20
23 percent utilization, and given the
24 need for perhaps regionalization,

1 are we going to put these Level 2s
2 out of business by not having
3 sufficient volume or not? And
4 again, without the outcome data, I
5 think we really need that piece of
6 information.
7 DR. FUNK: I don't know
8 what patients exactly went to the
9 Level 2s, but right now the
10 helicopters are, I'm assuming,
11 following the same criteria that
12 everybody does, that in New York
13 State a Level 1 equals a Level 2,
14 and if you meet trauma criteria you
15 go there, with a few exceptions --
16 burns, major chest, unstable pelvis,
17 the things that the Level 2s have
18 openly identified that they can't
19 do, don't want. You know, our
20 helicopter's practice is if a Level
21 2 is identified as being the closest
22 facility, as soon as the crew gets
23 on the scene, they'll identify what
24 the major injury is and have the

1 dispatcher call ahead. Do you have
2 the ability to care for a brain
3 injured patient today, a spine
4 injured patient, or whatever? And
5 the Level 2s have the opportunity to
6 say no, not today, thank you, or
7 yes, we do, and then we go there if
8 they are the closest. You know, it
9 is 20 percent, but what our concern
10 is, is do they then need to be
11 transferred out? Do they have
12 injuries that are more complicated,
13 and can we pick those patients out
14 by the fact that they were just sick
15 enough to meet criteria to get in
16 the helicopter? I don't know that
17 we have that information on our own.
18 And, you know, this was the entirety
19 of New York State. We think we're
20 missing some numbers, but it's 500
21 cases in helicopters over 3 months,
22 and 20 percent of those are the ones
23 that we're talking about going to
24 Levels 2s. So is that small number

1 going to hurt Level 2s
2 significantly, or is it worth it for
3 the benefit that the patients may
4 see? That's something we have to
5 look at.
6 DR. HENRY: Dr. Cooper.
7 DR. COOPER: First, I'd
8 like to congratulate both committees
9 on this excellent preliminary study,
10 but I do think we have to regard it
11 as preliminary at this particular
12 point in time, and basing our
13 conclusions on this study, I think,
14 would probably not be appropriate at
15 this particular point.
16 A couple of observations. The
17 trauma registry in New York State
18 has not, as we all know,
19 consistently shown a difference in
20 performance between Level 1 and
21 Level 2 centers, to say the least.
22 In fact, it's very difficult to
23 demonstrate any difference between
24 the mortality outcomes, and in some

1 years the Level 2s look as though
2 they have performed perhaps even
3 slightly better; although, the
4 difference has not been
5 statistically significant. But I
6 think the issue that Mr. Wronski has
7 raised, I think, bears some
8 consideration. There are some
9 simple questions we can ask that may
10 bear on this issue.
11 Mr. Wronski raised the issue
12 of a person walking out of a
13 hospital the same day that he or she
14 is transported there by helicopter.
15 While that may be appropriate on
16 some occasions, it is more likely to
17 be not appropriate. One might also
18 ask the question, is a patient who
19 is transported to a Level 2 then
20 subsequently transported to a Level
21 1 within a very short period of
22 time? Now, that would certainly be
23 a question that we could look at
24 that would bear on the question as

1 to whether Level 1 might be the
2 preferred, you know, site of final
3 destination. But I think that in
4 all of these discussions, and I
5 think Dr. Funk has really pointed
6 out, you know, that the literature
7 is very clear that there is benefit,
8 particularly in the trauma world, to
9 helicopter transport. At the same
10 time, most of these studies don't do
11 a terribly good job of taking the
12 time factor into consideration.
13 It's really more, did you have the
14 helicopter or did you not, not so
15 much, you know, was there a huge
16 time difference between the two.
17 Another factor that is not
18 perhaps considered as thoroughly as
19 it might be, is the composition of
20 the crews that ground transport and
21 helicopter transport can bring to
22 bear. Typically, helicopter
23 transport involves a nurse and a
24 paramedic, you know, and in some

1 circumstances ALS techniques, such
2 as chest tubes and so on, can be
3 placed and so on, that really expand
4 the scope of what is normally able
5 to be provided on the ground. So I
6 think all of these questions really
7 need to be considered before we
8 consider making any major changes in
9 policy.
10 DR. HENRY: Okay, good.
11 We generated a lot of discussion,
12 and we'll take some of this to the
13 trauma meeting. Any other
14 discussion?
15 MR. DELAGI: Actually,
16 just a couple of additional items.
17 The discussion that we just had, in
18 terms of trying to collect and share
19 in-hospital data, is a good segue
20 way into the next work item that
21 we've been working on this past
22 year. And we're continuing to work
23 with the Department on addressing
24 the ongoing issue of an apparent

1 disconnect between some of our
2 statutes and regulations and the
3 hospitals' statutes and regulations
4 with regard to hospitals sharing
5 data with the EMS providers in the
6 field. And, you know, I think this
7 is a good discussion to have because
8 I think we need to have access to
9 this kind of data. I understand the
10 hospitals' concerns about releasing
11 data, but we need to come to some
12 sort of an agreement about what is
13 appropriate and what is not.
14 Another work item that we have
15 was, as a follow-up to the release
16 of the QI manual and the regional
17 rollouts, we conducted a survey at
18 the Vital Signs Conference this past
19 October, and I would ask Sharon to
20 quickly present those findings.
21 They're actually kind of
22 interesting.
23 MS. CHIUMENTO: We had 268
24 surveys that were completed, and all

1 regions of the State were
2 represented; although, we only had
3 one from New York City and a range
4 up to 40 from Suffolk County. All
5 levels of providers were
6 represented. We only had one CFR,
7 but most of them were EMTs. We had
8 136 EMTs out of the 268, and then
9 another 30 percent or so were
10 paramedics. So those were the two
11 primary groups that responded.
12 The table that you see here,
13 what I did was, we had the yes/no
14 answers, and then a lot of people
15 checked off, unknown. They did not
16 know whether they had an agency
17 coordinator or whatever. And "NA"
18 is, they just didn't answer. They
19 just left it blank. So you'll see
20 that there was 235 people that
21 answered that they did have an
22 agency QA coordinator. It's 94
23 percent of the people who answered
24 the questions with either a yes or a

1 no, 80 percent of the total. There
2 were no regions that had less than
3 50 percent in that category. Agency
4 medical director; we had 94 percent
5 and 74 percent of the total; 94
6 percent of the yes/no's, 74 percent
7 of the total. Again, no one less
8 than 50 percent and no region less
9 than 50 percent. A large number of
10 unknowns and not applicable in that
11 particular category, however.
12 Agency committees, 70 percent and 66
13 percent. Three regions -- three
14 agencies -- sorry, three regions had
15 less than a 50 percent compliance
16 with that particular item. QI plan,
17 76 percent and 62 percent, again, a
18 very large percentage of unknowns
19 and not applicable in that
20 particular column. Two regions had
21 less than a 50 percent affirmative
22 response. Agency call review, 87
23 percent and 83 percent. There was
24 nobody -- no regions that had less

1 than 50 percent with that particular
2 item. Agency QA feedbacks, 74
3 percent and 72 percent. One region
4 had less than 50 percent. Agency QI
5 education, 73 percent and 62
6 percent, again a large component of
7 unknowns and not applicable in that
8 one. One agency less than 50 --
9 program agency less -- or region
10 less than 50 percent. And then the
11 one which we would expect to have
12 the lowest number on, was the
13 awareness of the New York State
14 manual because it just came out last
15 year, and we were in the process of
16 doing rollouts. So 55 percent and
17 54 percent on that with 7 regions
18 having less than 50 percent on that
19 particular item. Below that, there
20 is all -- the ranges for each of the
21 different regions, and I won't go
22 through all of that, but it varied
23 depending on the item as to what
24 percentage that region had.

1 On New York State QA/QI
2 initiatives, this was the manual
3 itself and how well it was being
4 received and whether people thought
5 it was useful or not. And you'll
6 see that our numbers are quite good
7 as far as the people who actually
8 saw it. So all of the hundred
9 people or so that actually -- 120
10 people -- 146 people -- 146 people
11 who actually saw the manual, most of
12 them felt that it was either highly
13 useful or somewhat useful, with the
14 most useful thing being the manual's
15 suggestions, with over 54 percent
16 highly useful. I did not evaluate
17 that by region because the numbers
18 were so small of responses in that
19 particular thing.
20 The last thing that was
21 evaluated was whether or not people
22 attended a rollout of the manual.
23 Twenty-three percent attended a
24 Department of Health rollout around

1 the State and 27 percent attended a
2 local rollout. The number of
3 regions with less than 50 percent,
4 there was 13 that had less than 50
5 percent attendance at a DOH rollout
6 and 16 regions had less than a 50
7 percent at a local rollout. And
8 then at the very bottom there are
9 the barriers that were noted.
10 People noted reasons why QA was not
11 being done in their regions or what
12 they saw were problems with the
13 process. There were 78 different
14 barriers that were noted. The most
15 common barriers were time
16 constraints. There were 37 that
17 replied that. Lack of staffing,
18 leadership issues, lack of
19 communication, lack of participation
20 or interest, limited knowledge or
21 training, no agency review of calls,
22 administration not supportive,
23 attitude, limited resources, poor or
24 no feedback, and a volunteer

1 mentality, and then the rest of the
2 barriers had less than five
3 responses each. Any questions?
4 DR. HENRY: Thank you,
5 Sharon.
6 MR. DELAGI: Okay, thanks,
7 Sharon. That was a lot of work that
8 was put into that in a relatively
9 short period of time. I think the
10 take-home message for us, obviously
11 as a community, is going into 2009,
12 we need to get this into the hands
13 of more providers, and we've already
14 encouraged our colleagues at the
15 program agency and regional council
16 level to help work with us going
17 forward on that.
18 The last item of business --
19 sir.
20 MR. WRONSKI: One of the
21 things I suggest is that the
22 Committee might want to, in the
23 process of sharing this, do like an
24 exec summary and say the services --

1 you know, some of the key things to
2 think about it in the survey
3 involved, there might be a couple of
4 things you might want to point out
5 that the survey really highlights as
6 critical. I know ambulance services
7 are busy. Sometimes they get a
8 survey, they take a quick glance at
9 it, but if you give them an exec
10 report as part of a letter maybe,
11 and say, by the way note this, as
12 well as the report, it might be
13 good.
14 MR. DELAGI: Thank you.
15 That's a good suggestion.
16 DR. HENRY: Dr. Cooper.
17 DR. COOPER: This may seem
18 an almost self-evident comment, but
19 a couple of years ago, as we all
20 know, Dr. Billittier led us all to
21 embrace the culture of safety within
22 EMS in New York State, and it's not
23 clear to me that there's, should we
24 say, a widespread understanding of

1 the intimate relationship between
2 that culture of safety and quality
3 improvement for individual patient
4 care. And while I think in some
5 ways it's obvious and implicit in
6 all the quality improvement
7 activities that have been
8 undertaken, we all know the
9 incredible importance and centrality
10 of patient safety in everything we
11 do these days, and I'm just
12 wondering if there might be some way
13 that that linkage might be even more
14 greatly strengthened.
15 MR. DELAGI: That's an
16 excellent point, Dr. Cooper.
17 Usually, when we think of the
18 culture of safety, we think about it
19 from the provider's safety
20 standpoint, but I can hear
21 Dr. Fairbanks in the back of my head
22 saying, "reporting near misses,
23 reporting near misses." And to try
24 to make that distinction between the

1 safety of patient care and the
2 culture of safety through QI is an
3 excellent point. That is something
4 very worthwhile.
5 The last item on our plate is
6 our continued work with New York
7 ACEP and defining some data points
8 here in our New York State EMS
9 system. And we have not seen a
10 preliminary draft from ACEP yet. We
11 expect that to come out probably the
12 end of the month or perhaps in early
13 January, but we did make some
14 progress on collecting information
15 on some of the New York State data
16 points. We hope to have a
17 comprehensive report done by the end
18 of the year, or certainly by the
19 February meeting. But as it relates
20 to some of the other discussions
21 with online medical control, we just
22 wanted to ask Dr. Dailey to give you
23 a summary review of some of the
24 things that he found in a very quick

1 survey that we put together to look
2 at some essential data points from
3 right here in New York State.
4 DR. HENRY: All right,
5 Mike.
6 DR. DAILEY: I'll make
7 this pretty brief, and at the same
8 time Lisa is going to go through the
9 slides. These are incomplete data.
10 I've just filled in the last of the
11 data points over the course of the
12 last hour or so. We've gotten the
13 last surveys out to the right
14 people, so we should have a complete
15 report through Mr. Delagi in
16 February.
17 Briefly, we looked at pain
18 management and online medical
19 directions as well as both access to
20 online medical direction and then
21 how it was accomplished. We got all
22 but four of the regions initially.
23 We'll have complete data, as I said,
24 in February.

1 Briefly, we started by asking
2 how many regions had pain management
3 protocols. As you would all
4 imagine, that was a hundred percent
5 which was an important place to
6 start. We then looked to see how
7 many employed critical care techs as
8 well and found out that this was
9 there in a significant proportion of
10 the regions, but one did not.
11 We then moved forward into
12 what types of pain management
13 procedures were out there. I was
14 very encouraged to see that half of
15 the REMSCOs that replied have
16 standing order processes in place
17 for morphine administration. That
18 means that we have gone a long way
19 in just the last couple of years.
20 And 40 percent of the REMSCOs
21 reported that they are in the
22 process of putting fentanyl programs
23 in place.
24 As I reported this, we also

1 got some news from the Bureau, and I
2 bring caution to every agency that
3 has a fentanyl program in place to
4 remember the requirements associated
5 with that and that there are
6 significant administrative
7 requirements there that need to be
8 completed. This is a process that
9 brings significant concern to the
10 Bureau of EMS and Controlled
11 Substances and we need to make sure
12 that all of the administrative
13 requirements are being met. That
14 means quarterly reports need to be
15 filed. I'm sorry, off my soapbox.
16 You're welcome.
17 DR. HENRY: It's over
18 there.
19 DR. DAILEY: The soapbox
20 is over there. Thank you very much.
21 I appreciate it. And Lee, of
22 course, is sitting behind me, where
23 I thought she was standing --
24 sitting to stab me but in turn she's

1 to pat me on the back for saying her
2 piece for a change.
3 Thirty percent of the program
4 agencies report the use of Toradol,
5 and only one has Tylenol available
6 to their providers.
7 There is no required pain
8 scale at 40 percent of the agencies.
9 The others have a conglomeration of
10 multiple different types of pain
11 scale in order to be able to judge
12 pain. That's important. As the fat
13 man says in the House of God, to
14 find a fever you have to check a
15 temperature. If you're not finding
16 out whether or not your patient has
17 pain, you're not going to treat him.
18 Online medical control or
19 medical direction is provided by PAs
20 in 15 percent of the regions
21 surveyed. That's something that we
22 could continue to give attention
23 from Medical Standards. In 25
24 percent of the regions, there is

1 triage to physicians, so the phone
2 or the radio is answered by either a
3 nurse or a prehospital provider, and
4 then a physician is called to the
5 phone or the radio as necessary.
6 Access, this is interesting.
7 Eighty-five percent of the regions
8 report that they use recorded radios
9 for access to their medical
10 direction, and eighty-five percent
11 also report that they use cells.
12 So, we see a great number of places
13 where cell phones are beginning to
14 be used more and more for
15 discussions of medical direction.
16 On the other hand, recording of
17 those cellular communications is not
18 as widespread as we would like to
19 see. Ninety percent of regions
20 using them report that local
21 hospitals bear the responsibility
22 for that recording, but anecdotally
23 we hear that that is not being put
24 in place as much as we would like it

1 to be. This is as much for the
2 protection of the physician as it is
3 for the provider and ultimately is
4 for the protection of the patient.
5 It's in our interest to make sure
6 that these communications are
7 recorded.
8 And half of the program
9 agencies report that they have
10 formal requirements for medical
11 directors for ambulance agencies.
12 Those are being collected by Dr.
13 Kaufman, and it will be disseminated
14 at a later date. And for online
15 medical direction, 75 percent of
16 regions report that they have some
17 type of credentialing process to
18 make assure that the physicians
19 doing medical direction have
20 familiarization with local EMS and
21 protocols. Preliminary report
22 there?
23 DR. HENRY: Okay, thanks.
24 Any questions for Dr. Dailey?

1 Thanks.
2 MR. DELAGI: Anything
3 else, Dr. Kaufman? The last few
4 items, that we're just monitoring
5 program agency submissions for their
6 annual focused studies. And we
7 continue to put together our final
8 report on the rest of those data
9 points, and we hope to have that for
10 you by the end of the year or at our
11 February meeting. Thank you.
12 DR. HENRY: Unfinished
13 business. Let me raise an item.
14 With respect to the trauma center
15 closings, I don't know if you all
16 were aware, but there was an offer
17 for loan repayment for enhanced
18 reimbursement to bring physicians to
19 underserved areas, and it wasn't --
20 it was primary care; it was also
21 obstetricians; it was also surgeons.
22 Some people thought about trauma
23 center closings, whether or not they
24 would be covered, but when I checked

1 against the map they were not
2 designated shortage areas. I will
3 ask Marjorie to talk about this a
4 little bit too, but perhaps we're
5 amis in that, in not bringing to the
6 attention of the people responsible
7 for the program that there are
8 indeed geographic areas of the State
9 that are wanting for trauma care
10 because of the lack of surgeons,
11 orthopedists, neurosurgeons, what
12 have you, because there is a
13 mechanism to move doctors to area of
14 need. Again, let me remind you that
15 half of the physicians who train in
16 our residency programs leave the
17 State. So, it's not like there is a
18 paucity of doctors who are trained
19 in New York. It's really
20 distributed -- distribution and
21 keeping them here. So there is an
22 opportunity here. Marjorie, you
23 were involved in that.
24 MS. GEIGER: Thank you,

1 Dr. Henry. Dr. Henry is referring
2 to a program known as Doctors Across
3 New York. This was done in
4 partnership with the Medical Society
5 of New York. They were a big
6 advocate. In the past, the
7 Department made funds available to
8 physicians to support loan
9 repayments. This is a little unique
10 in that it provides seed money to
11 exceptionally young and upcoming
12 physicians to start a medical
13 practice in a medically underserved
14 community and it also, through a
15 competitive RFP process, will
16 provide funds to hospitals to
17 recruit physicians to augment the
18 services that Dr. Henry talked
19 about -- primary care, obstetrical
20 and to some specialty surgical
21 programs within those hospitals.
22 And again, the funds will provide
23 opportunity to recruit the
24 physicians, to help defray their

1 costs of medical malpractice, loan
2 repayment and practice costs. I
3 urge you to consult the Department
4 of Health's web page for the RFP
5 announcement on this program. And
6 those of you who are in known
7 medically underserved communities
8 should really make this information
9 available to your grant writer and
10 procurement officer at your
11 hospital. The funds are also
12 available to practices. So if you
13 know of colleagues in a community,
14 particularly those that provide
15 obstetrical and primary care, and
16 are seeking new physicians, they
17 should look at our Department's web
18 page. Thank you.
19 DR. HENRY: Dr. Cooper.
20 DR. COOPER: Dr. Henry, as
21 we all know, Commissioner Daines has
22 made access to emergency care a very
23 high priority for his administration
24 as Commissioner of Health, and I

1 think your comments a few moments
2 ago about our need to call to the
3 Department's attention the notion
4 that trauma is a special case in
5 terms of underserved areas of New
6 York State, I think is something
7 very, very worthy of our
8 consideration here. And I would
9 like to propose the idea that this
10 body join with the State Trauma
11 Advisory Committee and the State
12 Emergency Medical Services for
13 Children Advisory Committee, which
14 will be meeting in two days, to go
15 on record with the Commissioner in
16 stating that we believe that, as the
17 Doctors Across New York Program
18 unfolds, understanding that
19 legislature change may be required,
20 that underserved populations with
21 respect to trauma care need to be
22 considered as part of the overall
23 program. And if necessary, I'll
24 make that as a motion, but I'll take

1 direction from the Chair as to
2 whether you think that's
3 appropriate.
4 DR. HENRY: Well, I would
5 be interested if there is general
6 sentiment. I think, in fact, I
7 believe in that recommendation. I
8 think it's one of our obligations to
9 not only bring the sentiment across
10 but to identify regions where there
11 are shortages. So trauma care, we
12 can do that with our colleagues in
13 the State Trauma Advisory Committee.
14 We have maps. One was on the wall
15 there. It would be apparent to
16 people who don't even live there,
17 these big gaps in New York.
18 The other area is in terms of
19 certain specialties, and I don't
20 think there's any groups better than
21 the REMACs who know how far one has
22 to travel for certain types of care
23 within a region, whether it be
24 trauma or other. And unless that's

1 identified, no one is aware but the
2 local. You can't pool these
3 resources in, so I echo you. You
4 know, I believe in that, what you
5 proposed, and I think that's
6 something we should do. Whether you
7 want to make a motion or not, it's
8 up to you, but I think that's --
9 DR. COOPER: I'll make a
10 motion to that effect.
11 DR. HENRY: Is there a
12 second?
13 DR. MARSHALL: Second.
14 DR. HENRY: Any
15 discussion? So, all in favor of
16 that motion? Opposed? Abstentions?
17 Okay, so we have one work item.
18 Nassau is too many.
19 All right, other unfinished
20 business? Dr. McEvoy.
21 DR. MCEVOY: I just wanted
22 to check-in about if there was any
23 response from the STAC about the
24 tourniquet issue.

1 MR. WRONSKI: Yeah, the
2 STAC is going to review that. They
3 did not have an answer at the last
4 meeting. There was some discussion
5 about it, and there was -- you know,
6 from the discussion at the table, no
7 one knew of literature that
8 supported or did not support, you
9 know, the raising of the legs -- I
10 believe that's the simple way to say
11 that -- or bring the blood above the
12 heart. So they were going to do a
13 little research on their own, but
14 they didn't want to comment until
15 they took a look at what literature
16 is out there.
17 DR. MCEVOY: That's wise
18 of them.
19 DR. HENRY: Dr. Cooper.
20 DR. COOPER: I have the
21 honor of representing the American
22 Pediatric Surgical Association on
23 the national task force that's
24 working to identify new standards

1 for ambulance equipment. And the
2 final conference call was held
3 yesterday, and the issue of both
4 of -- of arterial tourniquets and
5 topical hemostats were brought to
6 the floor, both being issues that
7 have concerned us here in New York
8 State. The Committee was unanimous
9 in its conclusion that the current
10 literature, most of which is very
11 recent, supports the addition of
12 arterial tourniquets, commercially
13 manufactured arterial tourniquets,
14 as essential equipment on BLS
15 ambulances and by extension, ALS
16 ambulances. And also unanimous in
17 its view that topical hemostats
18 needed to be considered as optional
19 equipment on BLS ambulances. These
20 conclusions, of course, still have
21 to be approved by the four
22 organizations in question -- namely,
23 the American College of Surgeons,
24 the American College of Emergency

1 Physicians, National Association of
2 EMS Physicians and the EMS-C
3 stakeholder group. But the fact of
4 the matter is that NAMSP, as many of
5 you know, published a lengthy
6 literature review in its journal
7 this summer on prehospital emergency
8 care on the subject, and I'm told
9 that a position paper will shortly
10 be forthcoming on these issues as
11 well. So, I just wanted to give you
12 the latest update on that. I think
13 that the 2010 Guidelines Conference
14 from the American Heart Association
15 and the American Red Cross who will
16 also address this issue. And
17 preliminary sounding suggests that
18 tourniquets -- arterial tourniquets
19 are going to be back in terms of a
20 pretty strong first-rate
21 recommendation as well.
22 DR. HENRY: Okay. Any
23 other unfinished business?
24 MR. VAN ROEKENS: Just,

1 the last meeting I did ask that we
2 request that Commissioner Daines
3 send a letter to all hospital CEOs
4 regarding the overcrowding. This is
5 an ongoing problem every year. This
6 is really something that hospitals
7 have a duty to EMS and in terms of
8 access to help make better for heart
9 patients.
10 DR. HENRY: Okay. I do
11 know that there will be a meeting
12 December 18, and the Department's
13 preparing a release of another
14 document to address this very issue.
15 So a group that has been meeting on
16 the topic of crowding of hospitals
17 will be convening on December 18.
18 Part of the agenda is to look at
19 a -- such a letter to hospitals. I
20 guess they urge it, so they're
21 working on it, so it's positive.
22 Other unfinished business?
23 DR. MCEVOY: The one other
24 question that we talked about at the

1 last meeting was the Safety
2 Committee had given Medical
3 Standards a list of skills that were
4 performed in the back of a moving
5 ambulance, and I don't know if
6 that -- did that come back to
7 Medical Standards?
8 DR. HENRY: -- discuss
9 that today, but you're right, that
10 was on the list.
11 DR. MARSHALL: Yeah, no,
12 we didn't. We need to. I'll bring
13 it back at the next meeting.
14 DR. MCEVOY: Okay.
15 MR. WRONSKI: The one
16 piece of unfinished business from
17 last time was -- when it was
18 discussed regarding the AED's
19 availability on an ambulance,
20 whether all ambulances had them, and
21 there was raised information that
22 not all interfacility transports had
23 ambulances that were transporting
24 patients and had an AED on the

1 ambulance, or defibrillator. So a
2 staffer, who last time provided some
3 information, has done what I
4 suggested and conducted a survey.
5 We have -- and I thank him for that.
6 He did a good job. It's not
7 complete data, but 20 -- we reached
8 out to counties. Twenty-nine
9 counties in New York State responded
10 as of now. That's roughly half, all
11 right, of the counties in the State.
12 And we also reached out to the 23
13 largest commercial services in the
14 State, or the largest services,
15 regarding information. Preliminary
16 information says that the -- that
17 the non-commercial sector or -- is
18 about 95 percent covered by
19 defibrillation capability, but this
20 includes first responders who were
21 non-transporting. And looking at
22 the data on the ambulance side, it
23 looks more like 99 percent or so of
24 the ambulances were covered. We'll

1 take another look at that to break
2 it out, but it's a high coverage
3 rate for that. For the commercial
4 service sector, it's 77 percent
5 coverage. However, that's a little
6 bit skewed, because when my staff
7 pointed out to me when we looked at
8 the data carefully, a particular
9 large service had a large sector of
10 its non-emergency responses, which
11 vehicles, which did not have an AED
12 or defibrillator available on the
13 ambulance but they did on all their
14 911s, but they were the outlier
15 service. If you remove that one
16 service from the data, it appears
17 that the rest of the commercial
18 sector is much higher in the 95 or
19 so percentile coverage of their
20 vehicles. So at least from half the
21 State reporting really, other than
22 one outlier, we essentially have 95
23 plus percent coverage in the system,
24 and that's even looking at the

1 non-transporting vehicles that we
2 have out there -- the BLS as well as
3 ALS. So, you know, the picture is
4 pretty good, in my view, and I think
5 that if we wanted to -- and I'm
6 going to suggest that the state
7 council look at this probably for
8 the February meeting, is propose
9 some language to them to add to the
10 equipment regulation that
11 ambulance -- if you're an ambulance,
12 a certified ambulance in this state,
13 that part of the equipment list
14 include a capability to
15 defibrillate. We won't lay out
16 whether that be a, you know, an ALS
17 machine or an automatic
18 defibrillator, just that you have
19 the capability to defibrillate. So
20 that will be put on the table.
21 Based on the information to date, it
22 seems like the system is pretty much
23 covered, you know, again, other than
24 one outlier.

1 DR. HENRY: Good. Someone
2 else have other unfinished business?
3 All right, new business.
4 Okay, one item -- yes, Sharon?
5 MS. CHIUMENTO: Just one
6 small thing. I'm one of the people
7 who was the liaison from EMS-C, and
8 I just wanted to announce that
9 Dr. Cooper is now the chairperson of
10 our EMS-C Committee. So I just
11 thought you might like to know that.
12 DR. COOPER: Thank you,
13 Sharon. That's not quite true. I
14 was asked by my colleagues to assume
15 that position, but I have not yet
16 been appointed by the Commissioner,
17 so I want to be very clear about
18 that.
19 DR. HENRY: All right,
20 yes. Some may have before you an
21 announcement of the Pharmaceutical
22 Safety Grant, and I would ask
23 Marjorie if you would like to fill
24 us in a little bit more about that?

1 MS. GEIGER: Thank you,
2 Dr. Henry. This is an initiative of
3 the Patient Safety Center. The
4 State of New York negotiated an
5 out-of-court settlement that
6 resulted in a several-million-dollar
7 award to the Department of Health to
8 undertake pharmaceutical safety
9 analyses and studies. We have three
10 solicitations on the HRI, which is
11 the Health Research, Incorporated
12 web page. In the packet before you
13 is a listing of these three
14 solicitations including the web
15 page. The hospital representatives
16 in the room, we encourage you to
17 look at what is known as PG No. 3.
18 We're soliciting proposals from
19 hospitals, nursing homes and
20 community health care organizations
21 to tell us an idea of how they hope
22 would, using these state funds,
23 alleviate medication errors among
24 their patients, improve

1 communication chain and a
2 pharmaceutical distribution supply
3 chain. Susan Senecal and Amy Yost,
4 the two staff members responsible
5 for this project, are in the
6 audience, and they are available if
7 you have any questions. You can
8 also post an e-mail request to
9 myself or Miss Senecal. Thank you.
10 DR. HENRY: All right,
11 thank you. Dr. Van Roekens.
12 MR. VAN ROEKENS: Yeah,
13 two pieces. One, I will be in our
14 region looking at the STEMI
15 transfers as we've sort of localized
16 some of the approaches. Even though
17 there is not a STEMI designation
18 anywhere outside of the city, we
19 still feel that patients should go
20 to the most appropriate place, and
21 there have been various iterations
22 of that worked out so the patients
23 are taken to the most appropriate
24 place.

1 The second announcement is
2 that I will be stepping down as
3 chair of the Hudson Valley region.
4 I'm taking a new position, as some
5 of you know, in Manhattan, as the
6 Chief Medical Officer of the
7 Manhattan Physician Group, and so it
8 has been a privilege serving here.
9 DR. HENRY:
10 Congratulations, and we thank you
11 for all of your years of service
12 here. You've been very faithful and
13 loyal and come to most of the
14 meetings and always contributed, so
15 good luck.
16 Dr. Dailey, do you want to
17 bring this up at this point?
18 Introduce a discussion?
19 DR. DAILEY: The Hudson
20 Mohawk REMAC wrote a letter to
21 Mr. Wronski and to Dr. Henry with
22 regards to our concerns over
23 patients sitting on ambulance
24 stretchers for extended periods of

1 time in emergency departments. In
2 particular, our concerns were a
3 little bit different than most.
4 Normally when we look at ED
5 overcrowding, which really is a
6 symptom of hospital overcrowding,
7 our concern is more about just the
8 patients. In this case, our concern
9 was for the providers themselves.
10 Our ambulances are out of service
11 for extended periods of time. This
12 is putting a great deal of stress on
13 our commercial providers, not to
14 mention our volunteers, and also
15 equally important, it adds another
16 level of stress. Our providers are
17 continuing to provide medical care
18 to patients once they have come
19 through the doors of a hospital.
20 Our brief understanding, the Nurse
21 Practice Act, is that this creates a
22 violation of Department of Education
23 regulations. What our REMAC has
24 asked this body to discuss and the

1 State to investigate, is how we can
2 continue to provide care and have
3 our prehospital providers caring for
4 patients inside hospitals safely in
5 this time of great concern. We
6 don't pretend that there is going to
7 be an easy answer. We would like to
8 see all patients off stretchers as
9 quickly as they get there with
10 reports taken by licensed
11 in-hospital providers and our
12 patients -- and our providers back
13 out in the street. We realize that
14 is not going to happen. We want to
15 make sure that our critically ill
16 patients and our patients in pain
17 can continue to get care inside the
18 hospital without putting our
19 providers in danger of some type of
20 regulatory action by the Department
21 of Education, if it were to be
22 recognized by somebody that was
23 upset about it. Thank you.
24 DR. FUNK: I have another

1 comment along those lines. I'm also
2 concerned for the paramedic's
3 safety -- the paramedic that arrives
4 at a hospital to pick up a patient
5 to provide interfacility transfer is
6 in the same exact position. They
7 arrive and are put in a position to
8 assess a patient, provide
9 interventions to stabilize them for
10 transfer within the walls of the
11 facility that the patient is in. So
12 two situations that are happening
13 every single day across this State
14 that we're asking paramedics to
15 operate in -- outside of what we
16 know to be accepted law. So we need
17 to discuss this and figure out how
18 we're going to fix the issue to
19 protect our providers.
20 DR. HENRY: Well, we can
21 have continued discussion on this.
22 I invite your thoughts, but just for
23 information, as you read the minutes
24 from the last meeting, there was a

1 note that we would be putting our
2 concerns about the Department of Ed
3 together in trying to get a joint
4 meeting. And Mr. Wronski, you know,
5 informs me that Hospital Services is
6 collecting information from the
7 Department's point of view for such
8 a meeting. So that's still on the
9 agenda, and this sounds like
10 something that would be an
11 appropriate topic. I don't know if
12 you want to add to that.
13 MR. WRONSKI: Yeah. This
14 really dovetails with the other
15 meeting I had talked about, the
16 training in the hospitals. Really,
17 one complements the other and should
18 be handled at the same time.
19 Hospital Services has agreed to work
20 with us, and we're going to have a
21 meeting with them, lay out a
22 strategy on how we're going to head,
23 which in my way of thinking, is
24 going to have to include -- at the

1 table. Try to get that done in the
2 first half of next year. But just
3 to underline my thinking and
4 regarding EMS personnel come into a
5 hospital with a patient and that
6 patient is not taken from them
7 immediately, obviously when you go
8 through the hospital doors and
9 you've identified yourself to a
10 nurse, that patient now is
11 understood to be the hospital's
12 because the nurse or the PA, or
13 whoever greets you at the door who
14 works for the hospital, has taken
15 some information regarding that
16 individual and that you've arrived
17 and you're there for care. But
18 sometimes they ask you, listen, stay
19 with the patient, we'll get somebody
20 to you and that, as I've heard in
21 some cases, takes some time. So,
22 what do you do if you've got lines
23 running and such and you're in the
24 hospital walls? In my view, as long

1 as the crew has clearly made efforts
2 to turn over care and they've said
3 we will get to you but they have not
4 yet done so, they are safe to
5 continue that care until the
6 hospital relinquishes it. However,
7 there is also, you know, at some
8 point a need for the EMS crew to
9 leave. So what do you do? Are you
10 going to be charged with patient
11 abandonment at that point? Well,
12 you need to be absolutely clear that
13 if you're about to leave because
14 you've got to go, you've got to get
15 out of there and cover your
16 community, that you've identified
17 with the triage nurse, we're on our
18 way out, that this patient requires
19 the care and we are on our way out
20 so that there is clear documentation
21 of that on your call report, the
22 nurse, or whoever is the appropriate
23 person, has been identified and
24 spoken to. I agree, it's a gray

1 area. If somebody complains about
2 the care you give them, I will tell
3 you that I make a pledge to you that
4 as long as you were reasonable in
5 what you were doing, I'll support
6 what you did. That does not mean
7 that I won't open an investigation
8 on you. Okay? So you need to know
9 that in order to clear you it might
10 require, okay, if I get a complaint,
11 that I open a case on you to look at
12 what happened. Some people believe
13 that that's abusive, but the only
14 way I can get to some facts is, in
15 fact, open an investigation. But
16 the investigation could be closed in
17 your favor, again, if you do these
18 things. So protect yourself, and
19 make sure the hospital knows you're
20 there when you get there, and make
21 sure they know when you are leaving,
22 if you feel you need to go. It's
23 not your job to be an employee of
24 the hospital, but at the same time

1 you have a patient, so there's
2 that -- can I tell you is it five
3 minutes I'm talking about? It is
4 twenty? Is it thirty? I can't.
5 I've got to leave that to your
6 judgment, just like I do the BLS
7 protocols which are -- yes, they're
8 specific, but they're also a
9 guideline. What I will do is bring
10 this up specifically with our
11 council's office. Can they give us
12 some advice, and we will put this on
13 the table with the other issue on
14 training as we move ahead to get
15 that meeting with state ed.
16 DR. HENRY: Dr. Cooper.
17 DR. COOPER: I don't mean
18 to prolong this discussion
19 unnecessarily, particularly given
20 the fact that Dr. Henry has
21 indicated that this will be taken up
22 at the appropriate time in an
23 interdepartmental meeting, but I do
24 think it's important to put on the

1 record, you know, a simple fact that
2 all of us here understand really
3 viscerally, and that is that
4 medicine and law are very different.
5 The state Public Health Law draws a
6 very, very stark line at the
7 Emergency Department door as we all
8 know. Article 30 regulates what
9 happens outside that door, and
10 Article 28 regulates what happens
11 inside that door. The problem is,
12 as we all know, that, in terms of
13 patient safety, handoffs of patients
14 are typically the most dangerous
15 moments in the course of care. And
16 handoffs occur between health care
17 providers on a regular basis in many
18 cases, in fact in most cases several
19 times a day. And those handoffs
20 require not one provider to be with
21 that patient but the two providers
22 to be with that patient during that
23 period of handoff for however long
24 that handoff takes, and it's very,

1 very difficult to sort of draw a
2 line between those two providers and
3 talk about one inside and one
4 outside, and so on. I think that
5 the points that Dr. Dailey and Dr.
6 Funk have made are absolutely on
7 target. But I think that, as this
8 discussion proceeds, we need to be
9 very, very mindful that that
10 division between Article 28 and
11 Article 30, while it might make
12 legal and regulatory sense, it
13 doesn't make medical sense.
14 Prehospital care is emergency
15 medicine practiced outside the
16 hospital under the direction of
17 appropriate medical oversight,
18 medical control physicians. We all
19 understand this. And medical care
20 is a continuity that begins with
21 prevention and extends all the way
22 through rehabilitation. And so I
23 think our conversations really have
24 to be predicated on that notion. We

1 really have to be looking at ways to
2 preserve that continuity of care and
3 insuring the safety of handoffs
4 rather than focusing on
5 jurisdictional boundaries which may
6 have meaning in law but have little
7 meaning in actual -- in the actual
8 practice of medicine.
9 DR. HENRY: Yes, Mr. Zeek.
10 MR. ZEEK: Thank you.
11 Dr. Cooper, I wholeheartedly agree
12 and I've thought for many years that
13 this situation begs for some kind of
14 legislative solution that would hold
15 EMS providers to the same standards
16 inside the hospital as outside the
17 hospital and absolve hospital
18 providers from responsibility issues
19 until a proper handoff can be
20 accomplished. And I think that's
21 the only real fix that this is going
22 to happen, because it's the
23 emergency department and, as Dr.
24 Funk points out, often times the ICU

1 or a floor where EMS meets hospital
2 medicine, and there ought to be some
3 kind of legislative fix that
4 recognizes the realities of this
5 situation and creates a situation
6 where responsibilities and
7 liabilities are recognized and
8 eased. Thank you.
9 DR. HENRY: Any other
10 discussion? Any further thoughts
11 would be welcome. You can forward
12 them to us. Any specific questions
13 to be proposed.
14 All right, any other new
15 business? Okay. Well, then hearing
16 none, I guess our next meeting is
17 February 17 and 18. For us it will
18 be the 17th in the Crown Plaza in
19 Albany, so we'll entertain a motion
20 for adjournment.
21 DR. FUNK: As we're
22 entertaining the motion to adjourn,
23 I'm just wondering if the folks from
24 Legislative want to go ahead and

1 start now, as opposed to waiting 35
2 minutes, and then we can just move
3 through the rest of the day's
4 agenda, if that meets approval from
5 the Legislative people.
6 DR. HENRY: Motion to
7 adjourn?
8 DR. MARSHALL: So moved.
9 DR. HENRY: All right.
10 All in favor?
11 SPEAKERS: Aye.
12 (Whereupon, the meeting
13 concluded at 3:30 p.m.)

1

1

1 C E R T I F I C A T E
2
3
4 I, Kyle Alexy, a Shorthand Reporter
5 and Notary Public in and for the State of
6 New York, do hereby certify that the
7 foregoing record taken by me is a true
8 and accurate transcript of the same, to
9 the best of my ability and belief.
10
11
12
13 ______________________
14 Kyle Alexy
15
16 DATE: December 2, 2008