
NEW YORK STATE
EMERGENCY MEDICAL ADVISORY COMMITTEE
(SEMAC)

Tuesday, June 9, 2009
1:30 p.m.
Crowne Plaza
30 Lodge Street
Albany, New York

APPEARANCES:

Mark Henry, MD, Chair
John Broderick, MD
Sharon Chiumento
Rick Cook
Craig Cooley, MD
Arthur Cooper, MD
Tim Czapranski
Michael Dailey, MD
Jack Davidoff, MD
Robert Delagi
John DeTraglia, MD
Terry Fairbanks, MD
Carl Goodman, MD
John Hassett
Timothy Haydock, MD
Bradley Kaufman, MD
Joshua Kugler, MD
August Leinhart, MD
Lewis Marshall, MD
Michael McEvoy, PhD
John Morley, MD
Daniel Olsson, DO
Edward Wronski

1 DR. HENRY: I'd like to call the
2 meeting to order and welcome everyone. Thank you
3 for coming. So we have a pretty full agenda today
4 and we'll take a roll call, just to make sure
5 everyone gets introduced.

6 (Roll call taken.)

7 DR. HENRY: Thank you. And also at
8 the table with us we have Dr. Morley, the medical
9 director for the office of health systems
10 management. And Mr. Cook, would you just
11 introduce yourself and where you're from?

12 MR. COOK: I'm Rick Cook. I'm the
13 deputy director for the office of health systems.
14 As some of you may know, Jim Kline is the deputy
15 commissioner, so I work directly with Jim and,
16 unfortunately, with Dr. Morley to try to manage
17 things, if those two go together. But Mr. Wronski
18 asked me if I could attend some of these meetings
19 and I welcomed it. I have been with the
20 department for a year and a half, primarily
21 focusing on patient safety and budget issues, so
22 it's nice to get out and start to hear about the
23 real program issues. So I thank you for the
24 invitation.

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1 DR. HENRY: Thanks for coming. So
2 it's been a -- quite a season since our last
3 meeting with the predominance of the respiratory
4 illness, with the emergence of H1N1, and the
5 impact that's had on emergency preparedness and
6 receipt of patients in emergency departments and
7 calls to EMS. It's a good wake-up call for us to
8 think about our own regions and statewide and we
9 will discuss this in much more depth tomorrow
10 after the SEMSCO meeting when the disaster
11 committee meets. And that will be one of the
12 topics, main topics, of discussion. So it's a
13 sobering issue, but one of the reasons we're here
14 together.

15 I have a few letters of
16 correspondence from Dr. Cooper in his chair
17 position for the EMS for Children advisory
18 committee. And since Dr. Cooper's here, I'd let
19 him just speak for the content of these letters
20 and share them with you all.

21 DR. COOPER: Thank you, Dr. Henry.
22 The EMS-C sub-committee has met twice since the
23 last meeting of the SEMAC. The -- and three
24 issues were discussed to be forwarded to the SEMAC

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1 for additional consideration. Two are relatively
2 straightforward; a third is more complex. I'll
3 deal with the -- the first of them, or the simpler
4 of them, I should say, first.

5 At the February meeting, the notion
6 that protocols had become quite a bit more complex
7 than they have when many of us around this table
8 joined with EMS systems is not news to anyone.
9 But it does sometimes happen that protocols that
10 are used a little bit less frequently than others
11 are not always perfectly remembered by
12 pre-hospital providers, just as treatments in the
13 emergency department are not necessarily always
14 delivered in precise order. And the committee
15 decided to ask that the SEMAC consider working
16 with the Department to direct that all ambulances
17 and advanced life support first response services
18 carry a current copy of the statewide basic
19 protocols and regional advanced level protocols on
20 their units. This issue, I think, will come up
21 again under the medical standards sub-committee
22 report, but there was pretty clear consensus, I
23 believe, that that made sense.

24 The second issue has to do with the

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1 NEMSIS data set. As many of the know, the
 2 Department received a grant from the Governor's
 3 traffic safety committee to look into how New York
 4 State's data might be made compliant with the
 5 National EMS Information System or NEMSIS.
 6 NEMSIS, as many of you know, contains several
 7 hundred date points, 479 if my memory serves me
 8 correctly, although Lee Burns, I'm sure, has the
 9 precise number. And, clearly, we do not collect
 10 anywhere near that number of data points. Most of
 11 those data points turn out to be demographic data
 12 points, which can be obtained from other sources,
 13 but the Department is looking into how those can
 14 be incorporated into our own data collection
 15 system. And the committee wanted to go on record
 16 as strongly supporting the Department's initiative
 17 in terms of making New York State's data set
 18 compliant with the national system so that we can
 19 compare our results with other EMS systems
 20 throughout the nation.

21 The third issue that is of note has
 22 to do with the visit that this committee had from
 23 the CARES Foundation at its winter meeting. As
 24 you remember, the CARES Foundation focuses on,

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1 primarily, children with congenital adrenal
 2 hyperplasia, but also other conditions that cause
 3 acute adrenal insufficiency. And they approached
 4 SEMAC with a request that it consider the addition
 5 of corticoid steroid administration to the
 6 protocols for children and adults, for that
 7 matter, with signs and symptoms of acute adrenal
 8 insufficiency. The EMS for Children advisory
 9 committee considered this at its recent meeting,
 10 having heard from the CARES Foundation
 11 representatives at the February meeting, and
 12 concluded that there is a place for pre-hospital
 13 administration of corticosteroids to patients with
 14 acute adrenal insufficiency under a certain number
 15 of conditions -- a certain constellation of
 16 conditions. The first being, of course, that the
 17 patient be adequately identified by a medic-alert
 18 bracelet or some other similar mechanism. Second,
 19 that the patient show signs and symptoms of acute
 20 adrenal insufficiency. Third, that treatment be
 21 initiated for -- for Addisonian crisis with
 22 oxygen, volume resuscitation, and where
 23 appropriate, dextrose. And last, that under those
 24 circumstances, that glucocorticoid therapy or

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1 corticoid steroid therapy be administered.

2 The committee is aware, of course,
 3 that most patients are prescribed hydrocortisone
 4 rather than methylprednisolone, the former having
 5 a greater mineralocorticoid effect, but the latter
 6 having sufficient mineralocorticoid effect in
 7 pharmacologic doses, that it could serve as an
 8 effective substitute, which is important because
 9 many, many regions already authorize the use of
 10 methylprednisolone as part of regional formulary.

11 So when this was presented to the
 12 medical standards committee this morning, there
 13 was general consensus that it made sense to permit
 14 this administration under appropriate
 15 circumstances, that training, of course, would be
 16 required, and that, where possible, it could be
 17 seen, if you will, almost as a form of
 18 self-administration or assistance with
 19 self-administration of a previously prescribed
 20 medication, in the sense, of course, that the
 21 family can authorize the self-administration on
 22 behalf of a child who is not able to administer
 23 that or grant that consent.

24 So that's -- that's the gist of the
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1 letter. The fact is that acute adrenal
 2 insufficiency, as everyone knows, has a very high
 3 morbidity and mortality, while the downside of
 4 administering a single dose of corticosteroids is
 5 virtually without side effects. So the
 6 risk-to-benefit ratio seems all to the good, and
 7 for that reason, the EMS-C committee asks that the
 8 SEMAC consider this.

9 So that, again, sums up the major
 10 issues that were discussed at the EMS-C
 11 sub-committee.

12 One informational item is that the
 13 revised American College of Surgeons, American
 14 College of Emergency Physicians ambulance
 15 equipment list has been prepared and circulated,
 16 and in a separate letter to Mr. Faeth, as chair to
 17 the council, we've asked that the council consider
 18 adopting the national standards for ambulance
 19 equipment as our own. Thank you.

20 DR. HENRY: Thank you. That is the
 21 communication we received. Next item of business
 22 is approval of the minutes from the last meeting.
 23 Are there any corrections, additions, deletions of
 24 the minutes? If not, we'll entertain a motion to

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1 accept them. Okay. So moved. Is there a second?

2 All in favor?

3 SPEAKERS: Aye.

4 DR. HENRY: Opposed? Okay. We

5 accept the minutes.

6 All right. The next item of
7 business is a report from Tim Czapranski from the
8 Rochester area, Monroe County, on the alternate
9 destination project that we heard about a year
10 ago, year and a half ago. So they've undertaken
11 this project. It's something that sparked a lot
12 of interest and we look forward to your report and
13 welcome you to give that now.

14 (Whereupon, an off the record
15 presentation was given to the council members by
16 Tim Czapranski.)

17 DR. HENRY: I'd like to go to the
18 reports of the standing committees. The first is
19 -- I'd like to start with is quality
20 improvement/quality assurance and Mr. Delagi and
21 Dr. Kaufman. Bob, you and Brad, can you give a
22 report from your group and are you going to speak
23 to the handout on the report card?

24 MR. DELAGI: Yes, we are, and we

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1 apologize for the sidebar conversation.

2 DR. HENRY: That's all right.

3 MR. DELAGI: We'll address the
4 handout first.

5 DR. KAUFMAN: The QA sub-committee
6 was tasked with reviewing the national ACEP report
7 card. So as way of a little background, in 2006
8 ACEP put out a report card evaluating the state of
9 emergency care throughout the United States and
10 gave grades on a state-by-state basis. They put
11 out a second version of this report card in
12 January of 2009. With the 2006 version, the
13 evaluation committee reviewed the report card and
14 some data points and we similarly reviewed the
15 report card, the one that came out recently in
16 2009. What you have in front of you is a brief
17 review of the report card. I think that you'll
18 see the difference from the 2006 report card in
19 they chose many more metrics to review. In
20 addition, they now have five categories of
21 evaluations. In the 2006 report card, they had
22 four. Again, the goal of, I think, the report
23 card is to generate discussion on the issues
24 surrounding emergency care throughout the country.

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1 I think they chose data points that they thought
2 they could obtain successfully that allow for that
3 discussion. Therefore, the QA committee reviewed
4 the report card and similarly chose just a subset
5 of the data points, which we chose to review more
6 carefully and to present in this report, which may
7 or may not generate specific discussion for those
8 data points. Certainly, there is no perfect
9 answers for many of the questions, and the
10 recommendations may not be accurate, but it should
11 generate discussion, which is the goal. We handed
12 out evaluations, which actually had some changes
13 which were made in our evaluation committee today,
14 which I will point out as we go along.

15 But just briefly, you'll see New
16 York State received a grade, an overall grade, of
17 C, which is better than the C minus that the
18 country received as a whole. EMS tends to fall
19 into a couple -- while there are pertinent
20 indicators in all the categories, certainly the
21 quality and patient safety environment, in which
22 New York State got an A minus, has a lot of EMS
23 pertinent data points as well as disaster
24 preparedness, where New York State also got an A

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1 minus.

2 If you'll see, what we did was
3 reviewed 22 of the 114 data points that we thought
4 were particularly interesting for this committee.
5 Instead of -- instead of giving where the data was
6 from, we decided to first list the metric and then
7 discuss whether that data point, we felt, was to
8 be accurate. So sometimes, for instance, in the
9 first metric, accredited chest pain center per one
10 million population, they list as 0.3. This data
11 point was not felt to be accurate for New York
12 State. It was found by those hospitals that
13 enrolled in an online chest pain database, which
14 is not accurate, as we know. We currently do not
15 designate STEMI centers in New York.

16 So our second line where we talk
17 about data accuracy is just telling about how we
18 felt the data was accurate -- not necessarily good
19 or bad, but whether that data point was accurate.
20 And finally, there was a recommendation that was
21 given. I'm just going to point out two of the
22 data points for discussion here for time sake --

23 DR. HENRY: With respect to that
24 one, Dr. Kaufman, do you think they were accurate

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1 in their assessment or not?

2 DR. KAUFMAN: No. For the first
3 metric?

4 DR. HENRY: Yes.

5 DR. KAUFMAN: Well, we do not
6 currently have chest pain designated hospitals, so
7 0.3 is inaccurate. And that's why the accuracy
8 was poor.

9 DR. HENRY: Could I just ask as a
10 side bar, where are we with that? It seems like
11 we have been discussing STEMI centers for four
12 years or more.

13 MR. WRONSKI: Where are we with
14 that?

15 DR. HENRY: Five years?

16 MR. WRONSKI: I will answer that.
17 We're a little further along. Specifically, there
18 are cardiac regs that have actually been put into
19 final draft, which includes language which would
20 allow for the creation of centers that could
21 function as free-standing STEMI centers. The
22 broader context of regional STEMI systems is not
23 yet in prepared regulation, although there's
24 certainly been more than enough conversation about

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1 it. But there are cardiac regs, which are now
2 going through the final process, and they do
3 include language which would create the ability to
4 have these individual hospital STEMI centers.
5 Does that answer it?

6 DR. HENRY: Time frame is sort of
7 --

8 MR. WRONSKI: It's a long timeframe.

9 DR. HENRY: It's not probably an
10 accurate grade on that one. I mean, in my own
11 sense, it's astonishing to me with the advancement
12 we have with the cardiac advisory committee and
13 the rich data that they have that we haven't got a
14 robust of patients from the field to the centers
15 and see the data points -- see the results of the
16 efforts.

17 DR. DAILEY: Dr. Henry, does this
18 answer more to systems that don't exist within the
19 state, and not necessarily systems that haven't
20 been developed quite nicely at many locales around
21 the state?

22 DR. HENRY: Sort of ad hoc to get
23 around the fact you haven't done this in the
24 state. You have to take care of the patients, but

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1 with the force that we could. Dr. Morley?

2 DR. MORLEY: If I may, could you
3 just tell me, other than defining what the acronym
4 means, which everyone is familiar here with, what
5 is it that you mean by a STEMI center?

6 DR. HENRY: Well, we've been calling
7 them -- instead of heart centers so they would
8 have market power, you had to have an ST
9 evaluation MI, and if you were identified in the
10 field as having that on your twelve-lead then you
11 would be taken, preferentially, to a place that
12 committed to deal with you within ninety minutes
13 on the average for seventy-five to eighty percent
14 of the people that arrive. So you'd have door to
15 balloon - you know - within ninety minutes. You'd
16 meet the national target. You would see improved
17 survival, as demonstrated with everyone else. So
18 we've been struggling to get that done. We've
19 approved here guidelines three years ago, at
20 least, if not four, and we have never merged
21 totally with the cardiac advisory committee. As a
22 result, places like New York or other places have
23 had to, quote, sort of self-designate destination
24 protocols with certain hospitals, but individuals

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1 throughout the state have not benefitted from
2 this.

3 DR. MORLEY: The regs that Ed was
4 speaking of, clearly, would allow for an increase
5 in the number of institutions in the State that
6 would -- and not a dramatic increase, but an
7 increase of hospitals that would have cardiac
8 catheterization that would then be capable of
9 receiving a patient with a STEMI. I just asked
10 the question, because one of the struggles that we
11 had -- we've been working on those regulations for
12 eighteen months plus, and one of the things that
13 has caused the issue of STEMI to be put, sort of,
14 on a back burner is the complexity over a
15 regulatory affiliation between EMS and STEMI,
16 which is what it seems to be that you're
17 describing, a regulatory system. I'm not the
18 first person to say - it's been said many times -
19 that this alleged healthcare system that we have
20 in our country is not a system at all. And in our
21 discussions about regulations, it was a bit of a
22 struggle to come up with that regulatory
23 affiliation between the two. And not to say that
24 we can't try again and look at that -- and we,

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1 too, would like to develop that for sure, but we
2 are at least right on the precipice of seeing a
3 significant increase in the number of STEMI
4 capable hospitals, so that would be a next step
5 for sure.

6 DR. HENRY: I think the importance
7 of the mix, though, is that the cardiac advisory
8 group has very rich data that hospitals provide on
9 outcome, and we struggle getting data. We don't
10 have the financial clout behind a cardiac center.
11 You know. So the outcome from the trauma system,
12 we believe, has shown a twenty percent improvement
13 in survival in this state. And the studies around
14 the country of designated STEMI centers in
15 identifying people in the field who need them
16 consistently show improved survival. So if there
17 is one way we can make a big mark on the
18 population, this is our ability to triage
19 appropriately. But we'd like to be data driven,
20 and if we don't have the connection with the
21 cardiac advisory committee, we will not get the
22 hospital data in the richness that the patients
23 deserve. That's really the challenge, in my view.
24 So any help we'd appreciate, and I think that's

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1 why we wanted to look at these report cards,
2 because it's an outside look at us and it forces
3 us to have some metrics and see how we're doing.
4 DR. KAUFMAN: I'd like to note for
5 the record that that discussion makes this a
6 success, because that's the purpose to generate
7 that type of discussion. So we're well on our way
8 with metric --

9 I think there are interesting
10 discussion points with all of the metrics chosen
11 by ACEP for review, not only the twenty-two that
12 we reviewed in all depth, but all of them. I'll
13 just mention, briefly, a couple others that may be
14 worthy of some discussion.

15 Look at metric number six, funding
16 for quality improvement within the EMS system.
17 New York State received a "yes," so we got full
18 credit for that. We reported the data accuracy as
19 fair because we felt that while it is true there
20 is some funding for quality improvement, there
21 certainly could be more. And our recommendation
22 discusses that we should, in moving towards
23 improved quality improvement, work towards the
24 statewide electronic patient care report, which is

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1 an active project, as well as working
2 collaboratively with hospitals to insure the
3 interchange of data, which Mr. Delagi will comment
4 more about, which we discussed quite a bit at our
5 sub-committee meeting.

6 I will point your attention to
7 metric number eight, which looks at the adverse
8 event reporting requirement. Again, New York
9 State received full credit with a "yes." While we
10 felt this data was accurate, certainly for the
11 hospital sector, it was not necessarily true for
12 EMS. However, we learned from Ms. Burns that
13 there is going to be a reporting requirement,
14 which the safety TAG has developed and is ready to
15 be launched. So that was a positive finding.

16 And I'll just make one more comment.
17 Looking at metric number nine and ten, which are
18 looking at the 9-1-1 call receiving system and the
19 PCAP, as well as the giving of pre-arrival
20 instructions, this has actually opened up further
21 discussion at our committee level looking at a lot
22 of the specifics of the 9-1-1 call receiving
23 process, which we will continue to report on in
24 the future.

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1 We are certainly glad to discuss any
2 of these data points. We also continue to work on
3 specific data points and numbers that reflect what
4 we felt was of importance within New York State.
5 We are finalizing some of those and hope to share
6 those at the September meeting.

7 DR. HENRY: I have one other
8 question. The data on diversion -- it says,
9 States collect data on diversion. We have "no."

10 DR. KAUFMAN: There are numbers
11 there?

12 DR. HENRY: Number five. And on the
13 last report card, we said, No, we didn't collect
14 that. We recommended that perhaps we should
15 collect that. How can you manage what you don't
16 measure?

17 DR. KAUFMAN: Yes. That's a good
18 point. We did rate the data accuracy as good
19 because it is indeed "no," and that was the
20 discussion that could be generated is whether that
21 should be collected at the state level or at the
22 regional level or at community level and if that
23 would be worthwhile.

24 DR. HENRY: We had a discussion

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1 earlier at medical standards about one county's
2 definition of diversion. And the discussion was
3 there could be variation among regions and what
4 diversion means. So it's a serious issue to
5 divert ambulances away from hospitals. It's
6 certainly of concern to the Department in terms of
7 crowding, but here is a way we would have data,
8 because you tell the dispatcher, Don't send to me.
9 Right? But we don't collect it uniformly nor
10 systematically, nor does the Bureau have access to
11 it.

12 DR. MORLEY: There is a small, crude
13 measure in the HURD system that basically, just
14 three times a week, asks if you've been on
15 diversion. But that's very crude and it's very
16 limited. It is resource intensive to collect that
17 kind of information, but it is information we're
18 clearly very interested in.

19 MR. WRONSKI: One of the things I'll
20 put on the table, but this is -- although it's
21 futurist, it's really the near future at this
22 point, since we do have a grant to build a data
23 platform for EMS now and the city's collecting
24 electronically most of its data and a couple other

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1 regions are on board and coming on board. But the
2 NEMSIS data set -- and one of the things to do
3 when we look through that data set is the -- I
4 believe there is some information in there as to
5 whether or not there was -- you were diverted to
6 another hospital or not and we should look at
7 that. I believe that's in that 480 data elements
8 set somewhere. But -- but I agree, it is
9 something to look at.

10 One of the things I would pose to
11 this group and to QI is, Okay, you collected it.
12 What would you do with it? What would you do if
13 you found out that -- you know -- twenty-three
14 percent of the ambulances in the state were
15 routinely diverted past the hospital because they
16 were overcrowded? What kind of things would you
17 drive with that data? We already know we divert.
18 That's pretty clear. How much we divert is a
19 question on a day-to-day basis, but I pose to you
20 to also think about what should we do with that?

21 DR. HENRY: I guess it depends what
22 it means. If it's the old New York City law, that
23 you divert because it endangers someone's life,
24 then someone should go in and take a very close

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1 look at why conditions are such that lives are in
2 danger. It depends a lot on the definition of why
3 you're going on diversion. The nurse feels too
4 busy and they want to divert for a couple hours,
5 that's one thing.

6 DR. MORLEY: You might also find
7 that there are significantly different thresholds
8 for diversion, which would be an interesting issue
9 to -- to look at, review, and then address. There
10 are institutions, I suspect, that have a much
11 lower threshold that -- we're not all that much
12 interested in emergency room volume. We're
13 actually more interested in elective volume. That
14 could happen. And there are other institutions
15 that have a more community-based philosophy of,
16 We're here to be open as much as is humanly
17 possible. And we would be interested to know if
18 that variation exists and where it exists and then
19 pursue that.

20 DR. HENRY: I would ask the regions
21 to send in their definitions of diversion, as
22 Nassau has, to try to create it, so it's uniform,
23 and the data they have for a sample month. So we
24 can take a look at that and use it. Dr. Kaufman,

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1 did you have other items there?

2 DR. KAUFMAN: Certainly, there is
3 many interesting items on the report card. I
4 don't know how many you want to --

5 DR. HENRY: Did others see items
6 that they wanted to discuss? Well, thanks --
7 thanks for providing it in the format that you
8 did.

9 DR. KAUFMAN: I think if everybody
10 wants to review, we can discuss at any point. I
11 think many of these issues are not going away and
12 tend to open the door for longer term discussion
13 on many of the projects we're working on and
14 continue to work on.

15 DR. HENRY: Mr. Delagi, do you have
16 anything to add?

17 MR. DELAGI: I do. Thanks, Dr.
18 Henry. We learned today from the bureau of staff
19 report provided by Ms. Burns that the Governor's
20 traffic safety commission, grant year one progress
21 moving towards NEMSIS compliance, is well
22 underway. We are certainly aware and very
23 appreciative of Dr. Cooper's letter from EMS-C
24 encouraging compliance with the NEMSIS data set

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1 and support that.

2 The committee is also working with
3 the bureau on version six of the current New York
4 State PCR to include the currently missing data
5 elements for NEMSIS compliance. And if memory
6 serves me correctly, there's about thirty-two some
7 odd points that we need to add to the statewide
8 PCR to get silver level of compliance and we're
9 working with staff on addressing those issues.
10 We've already revised the electronic data
11 submission policy to require NEMSIS-compliant
12 electronic platforms and this will just be for
13 those who continue to use paper.

14 We've discussed this several times,
15 but we just want to get it on the record and I
16 think I have it accurate here today. And Ed,
17 you'll certainly correct me, but Lee and I kind of
18 put our heads together and we decided we both went
19 to the same school of bureaucracy, where we earned
20 our BS degrees, and we think we got it down. But
21 at this point, New York State has a verbal
22 agreement with NEMSIS compliance. Therefore, we
23 have technically signed on as a NEMSIS-compliant
24 state. Currently, we're not submitting or

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1 collecting that data, but several processes are
2 underway to achieve NEMSIS compliance at state,
3 regional and service levels. And that is the
4 official position as we see it today.

5 MR. WRONSKI: And I, as director of
6 EMS, condones that BS.

7 MR. DELAGI: Okay. I feel in good
8 company now. Thank you.

9 A major part of our meeting today
10 was the discussion centering around the sharing of
11 in-hospital and pre-hospital data, and we were
12 pleased to be joined by Mary Ellen Hennessy and
13 Ruth Leslie, the director and associate directors,
14 respectively, of the New York State Department of
15 Health's division of certification and
16 surveillance. And we had a very lively
17 discussion -- I think a very productive discussion
18 today. And it was kind of, in summary fashions,
19 just to give you some bullet points. In EMS we
20 tend to measure structure and process, and what we
21 sorely miss is outcome data to review our quality
22 of care. And in very short form, we know that
23 there are article 30 requirements for ambulance
24 services to do QI. We know that the bi-annual

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1 certification or re-certification process of
2 ambulance services requires a physician to sign on
3 as the QI director, and we know that the 405
4 regulations require hospitals to provide catchmen
5 area information to their ambulance services. But
6 having said that, there seems to be no link to say
7 that hospitals need to give us what we need, and I
8 think we went a long way today in achieving
9 significant steps in making that happen. We agree
10 that EMS, or patient care providers, are part of
11 the continuum of care, so the HIPAA hand should
12 not be a barrier to hospitals sharing information
13 with EMS. We made it very, very clear that we are
14 only interested in outcome data for the patients
15 that we bring in. We are not interested in
16 looking at the hospitals QI files to see how they
17 treat their patients. And that might have been
18 either a real or perceived barrier to sharing of
19 that data. We're seeking resolution to be
20 considered part of the healthcare team and
21 essentially making sure that we are just looking
22 at outcome data to judge our own efficiency.

23 We learned that stroke center
24 designations actually require information sharing

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1 between hospitals and EMS providers and we
2 understand the soon-to-be STEMI center regulations
3 will have that same requirement. So everything
4 that we're doing here today is very, very
5 relevant.

6 So the bottom line is that we need,
7 very desperately need, an article 30 and an
8 article 28 collaborative agreement, and we'll be
9 seeking the advice of counsel for their opinion as
10 to what can be done and what is required to be
11 done. And we need to make sure we have our own
12 internal interpretations of the continuum of care
13 in place.

14 We split this out into two distinct
15 pathways. The first one is dealing with the
16 general day-to-day routine quality improvement
17 with regard to outcomes of patients brought into
18 the emergency department, and the second pathway,
19 which is a markedly different in context and
20 process, is the full blown RFB approved
21 research-oriented studies or specific patient
22 outcome projects that would require more intense
23 abstracting of charts and things like that. Two
24 very different pathways that we're going to be

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1 pursuing.

2 So the recommendation that was
3 agreed to today was that there would be a letter
4 drafted by the folks that I had mentioned before
5 from the Commissioner reinforcing permission for
6 information sharing at hospital levels. We agree
7 that we would be bringing in the hospital
8 associations to insure that we have their buy-in,
9 and the DOH will draft a letter for review for us
10 to look at by July so that we can discuss this at
11 the committee level in August and hopefully have a
12 draft ready for the mail in September at our next
13 meeting.

14 And this is all very timely, by the
15 way, as we learned today that increases in
16 Medicare reimbursement for EMS transports will be
17 dependent on robust quality reporting by ambulance
18 services. So this is something, again, that is
19 very, very timely and something that is sorely
20 needed. So we are pleased at the progress on
21 that.

22 DR. HENRY: Progress?

23 MR. DELAGI: Progress. We got to
24 the table.

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1 DR. HENRY: It seems like we have
2 been talking about this for five or six years --
3 seven years. Okay.

4 MR. DELAGI: Well, we got to the
5 table and we left with a work plan.

6 DR. HENRY: It seems, also, that
7 there's great variation around the state and who
8 can get access and who can't.

9 MR. DELAGI: Yes. And we found that
10 to be very, very true. And there is no uniform
11 process across the state. Some hospitals and
12 ambulance services enjoy very robust
13 relationships, while others have no relationship
14 whatsoever. So one of the things that we seek is
15 consistency across the state for outcome data
16 sharing. We tried to do some followup --

17 DR. HENRY: Dr. Fairbanks, a
18 question, comment?

19 DR. FAIRBANKS: I just have a
20 question. Terry Fairbanks. And you probably have
21 addressed this, since I haven't been involved --
22 but I wonder if you use the word "outcome data" in
23 the letter if it might be more limited than we
24 really want, because at least with my system, we

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1 want more than the outcomes data when we transport
2 a patient. We want to know details about their
3 clinical course and more, so I just -- I guess I
4 want to raise the issue about the way we word it
5 so that hospitals can feel like they can give our
6 providers detailed followup information, just for
7 their interest and continuing education.

8 MR. DELAGI: Point taken. Very
9 good. Thank you.

10 In trying to get some additional
11 information as it relates to our work with the air
12 medical TAG and the appropriateness of helicopters
13 review that we had done a number of months ago, we
14 tried to get some outcome data on the patients
15 that were flown to trauma centers to try and find
16 out what happened to them as part of that safety
17 process. And we learned through our discussions
18 with the bureau that the STAC database, as rich as
19 it is, it is not contemporary to the degree that
20 it will allow us to track those patients that
21 we dealt with just a few short months ago. So we
22 kind of feel like we're at an impasse right now
23 and have run into the proverbial brick wall with
24 regard to addressing the mechanistic criteria and

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1 the use of air medical services from a safety
2 standpoint, because we are unable to follow the
3 patients that we had originally identified
4 recently. And certainly if anybody has any
5 suggestions, we're more than happy to take them.
6 We thought that this would be a good way to track
7 the folks, but apparently it's just not there yet.

8 And then our last item of business
9 was to begin some discussion on medical direction.
10 As our conference call took place last week and as
11 other committees take a look at medical direction,
12 much like we've heard all over the place, we have
13 multiple opinions and experiences and agree that -
14 you know - REMAC decisions are made as to who can
15 provide medical direction based on available
16 resources. So we will continue that discussion,
17 as will the other committees, and be glad to
18 participate in that as we move forward in the next
19 few months. And that concludes our report.

20 DR. HENRY: Thank you. Any
21 questions or discussion? I would just note that
22 with the STAC database, the state database, it's
23 slower by necessity because it comes from all the
24 regions, and I would think the best chance to get

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1 contemporary data is at the local level with the
2 regional trauma centers and area trauma centers.
3 So those quarterly meetings that most of them have
4 around the state would probably be the place to
5 interact.

6 MR. WRONSKI: Yeah. I mentioned
7 before, and I encourage this. If representatives
8 from the REMAC and council reach out and have a
9 discussion with their local counterpart for the
10 R-Tech (sic) and discuss how they might share
11 information in dual projects -- and because they
12 do have the ability to work with some regionalized
13 data and it might be very useful to you. On a
14 state perspective, just -- I was going to mention
15 this in my report. There is a STAC -- State
16 Trauma Advisory Committee and School of Public
17 Health report is being finalized right now, but it
18 includes data 2003 to 2006. Although they are
19 collecting 2007 and 2008, the final data set that
20 will be available soon really only ends in 2006.
21 So it's very useful, but it's not contemporary QI.

22 MR. DELAGI: And certainly to be
23 clear, not on knock on the STAC at all. It was
24 just that we thought a partnership with them would

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1 give us our outcome data, admissions, discharges,
2 and transfers for those patients and it turned out
3 not to be the case. That's all.

4 MR. WRONSKI: Yeah. But again, I
5 wouldn't discount -- do some exploration, because
6 sometimes if you take a look, say, at the 2006
7 year and see what your system looked like then, it
8 would be a good indication probably of what your
9 system is still doing, in most cases -- not all,
10 but in most cases. But you can always compare it
11 when you get that more contemporary data.

12 MR. DELAGI: Thank you.

13 DR. HENRY: We saw a very
14 interesting presentation from Dr. Bessy and Dr.
15 Hannum at the last STAC meeting on statewide data
16 for trauma systems, and the number of patients
17 going to trauma centers, which has progressively
18 gone up, and the change in mortality, which has
19 gone down, and what part of that is due to direct
20 transport by EMS versus transfers. And I'm going
21 to ask them to come to our next meeting, because I
22 think that would give us all support and a feeling
23 of accomplishment, because it has happened over
24 time and you can see it, you can chart it. So I'm

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1 sorry I didn't think of that this meeting.

2 MR. WRONSKI: We can do that and
3 they can do more of an EMS specific report so you
4 can see that specific information. And actually
5 by then, the state report will be out and you will
6 see outcome data for different hospitals,
7 etcetera. It is very interesting, and Dr. Henry
8 eluded to it but I'll underline it, that the data,
9 both the state data and a separate review of CDC
10 data and looking at New York State specific data
11 that took the same data points as CDC shows that
12 New York State as a system has improved in its
13 overall care of trauma. But on a national basis,
14 we are significantly better, statistically better,
15 than the rest of the country as a system in how we
16 care for trauma.

17 DR. HENRY: Dr. Kaufman?

18 DR. KAUFMAN: I'd just like to make
19 another comment on the letter that we are hoping
20 to have from the Department from the Commissioner,
21 because this is something I know we've spoken
22 about before with Dr. Morley and Mr. Wronski. In
23 conference calls and even developing a letter that
24 we're hoping will allow all of our EMS agencies to

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1 show to the hospitals -- to show them that they're
2 absolutely allowed to share the data. Certainly,
3 the following step would be to change to the
4 regulations of the laws as the first step. And
5 these two representatives that were there were
6 strongly supportive of developing that letter with
7 us. So we're really hoping that we'll go forward.

8 MR. WRONSKI: The -- listen, I'll
9 explore that. What you should know is that a
10 definitive letter that says to hospitals, "You can
11 give your data to EMS," is a little bit more
12 difficult than you think. And I ran into that not
13 too long ago, but that doesn't mean we might not
14 be able to come up with a letter that fosters
15 sharing of information. Getting down to the
16 nitty-gritty - you can open your medical file -
17 it's not going to happen. That would take
18 something else, but potentially we could work out
19 some language that would assist you locally.

20 DR. HENRY: Okay. Let's move to
21 medical standards committee. Dr. Marshall?

22 DR. MARSHALL: Thank you, Dr. Henry.
23 We'll keep our report short, as usual. The
24 committee met this morning. We have four action

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1 items to bring forward. The first two I'll bring
2 forward are protocols.

3 So the first motion to come forward
4 is from Nassau County REMAC. Nassau REMAC
5 developed protocols for diversion, which we've had
6 some discussion here this morning, or this
7 afternoon, as well as redirection, hospital
8 redirection. The hospital redirection policy
9 would allow the system to direct ambulances away
10 from a hospital if a hospital has three or more
11 ambulances waiting thirty minutes or more.
12 Diversion will also allow the hospital to call for
13 diversion as it does now if the hospital feels
14 they are unable to care for additional patients
15 being brought in. There was one comment this
16 morning in the diversion protocol in the policy
17 that specifically lists that diversion status does
18 not apply to patients who are in extremis,
19 including cardiac arrest, respiratory arrest,
20 unmanageable and insecure airway or trauma
21 patients. And a question was brought up about
22 this also not applying to patients presenting with
23 stroke and being transported to a stroke center,
24 and the reason that this was specifically left out

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1 from the Nassau regional EMS diversion protocol is
2 because all of the hospitals in Nassau County are
3 state-approved stroke centers, so we should
4 commend them for that. The other two protocols
5 are nerve agent, organic phosphate, poisoning
6 anecdote protocols for adult and pediatric
7 patients. And all four of those were approved
8 unanimously by medical standards and come forward
9 as a seconded motion to this body.

10 DR. HENRY: Any discussion? Any
11 comments from Nassau County about your diversion
12 or redirect?

13 DR. KUGLER: No comments really. I
14 appreciate the SEMAC for allowing us to be so
15 avant garde. I think the county is -- the county
16 is, as many know, a very compressed county with a
17 lot of hospitals in a small area serving a large
18 population, and I think the policies that we
19 brought forward are very symmetrical regarding
20 both EMS agencies and the hospitals. So I think
21 as the other regions look at ours maybe as a
22 template, they will also look at it from a
23 unbiased perspective and look at it from both
24 sides. And I think that's the only way you can

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1 move something like this forward.

2 MR. WRONSKI: I'd just like to
3 comment. Dr. Kugler and Mr. Haydock from Nassau
4 County, congratulations, for the record, on
5 putting this together. Because as you all know,
6 EMS doesn't have statutory authority to direct
7 hospitals, but what you had here was at the table,
8 representatives from the hospitals, from EMS and
9 from the county who all discussed how to deal with
10 their own local issues regarding hospital and EMS
11 redirection, and they came up with a model. And
12 as they've - you know - also told me, a lot of
13 this will depend on the cooperation of all
14 individuals as time goes on, and that's like any
15 protocol or policy. The system players have to
16 cooperate with each other on it. So I wish you
17 luck. I hope it works.

18 DR. KUGLER: Thank you.

19 DR. HENRY: Could we have a vote on
20 the first one, please? On the Nassau County
21 protocol, we'll call a vote, roll call vote.

22 (Roll call vote taken.)

23 DR. MARSHALL: Thank you. The next
24 is Mountain Lakes protocol. Actually, Mountain

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1 Lakes brought forward a pediatric anaphylaxis
2 protocol, which this body -- which, actually,
3 medical standards approved in February at our
4 February meeting. It was determined at that time
5 that the protocol did not go through the regular
6 and required distribution and comment period, so
7 it was returned to Mountain Lakes region and the
8 protocol then went through the required
9 distribution and thirty-day comment period and
10 they received no comments. So the protocol that
11 medical standards approved in February now comes
12 forward for a revote. It was revoted on at
13 medical standards and passed with one abstention.
14 And it comes forward as a seconded motion to
15 approve the Mountain Lakes pediatric anaphylaxis
16 protocol.

17 DR. HENRY: Any discussion? Okay.
18 Call the vote.

19 (Roll call vote taken.)

20 DR. MARSHALL: Thank you. The next
21 action item from medical standards comes forward
22 -- it was actually presented originally as a
23 protocol from Mercy Flight, which included the use
24 of Ketamine in pre-hospital settings for flight

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1 for certain situations. There was a lot of
 2 discussion this morning, including the safety and
 3 reliability of the use of Ketamine in certain
 4 situations and its preference over other similar
 5 medications that are used for similar purposes.
 6 There was also some discussion about one of the
 7 issues that was of concern, including the
 8 diversion of drugs. At the meeting this morning,
 9 we did have representatives from the bureau of
 10 narcotics enforcement, from the licensing program
 11 and a pharmacy consultant who were present just to
 12 listen and ask questions, not to really speak on
 13 it. And they were very, very helpful. After
 14 significant discussion, the motion that comes
 15 forward was a motion to add Ketamine to the state
 16 EMS formulary. And that's the motion. There was
 17 also discussion about use of reversal agents,
 18 which Atropine is the one for here because of the
 19 increase in secretions and the fact that when
 20 giving Ketamine, it's something -- you don't want
 21 to reverse the action of the drug other than the
 22 increased secretions. It has a short path life,
 23 ten to fifteen minutes depending on the route of
 24 administration and it's felt safe by all the

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1 members of the medical standards committee that
 2 were present this morning. So the motion is to
 3 add Ketamine to the state EMS formulary.

4 DR. HENRY: Is there any discussion?

5 DR. YOUNG: Just a clarification.

6 For the record, it's Mercy Flight Central as
 7 opposed to Mercy Flight, Washington, New York.
 8 There are two with the same name, to avoid
 9 confusion.

10 DR. HENRY: Yes. Dr. Morley?

11 DR. MORLEY: I wasn't present this
 12 morning and I regret that. I'm sorry that I
 13 wasn't able to participate. But just to add some
 14 information. Ketamine, when it was first created
 15 and first released and approved, it was considered
 16 to be the ideal anesthetic at that time. It was
 17 touted as the greatest drug to come out for
 18 anesthesia, and it was a few years later that they
 19 -- that the conclusion was reached that it's not
 20 quite as good as we thought it was. There are
 21 some issues. And it's actually a significant
 22 issue in the operating room, a problem. It's not
 23 favored at all. It's used very little. Now there
 24 are some very specific cases in which it's used,

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1 but the side effects of the tachycardia causing
 2 confusion in volume status is a significant issue
 3 in patients in the operating room, and I would
 4 think in a resuscitation trauma case, as well.

5 And my final comment, the
 6 hallucinations - this drug is clearly chemically
 7 related to LSD - the hallucinations can be very,
 8 very traumatic for some patients. So I don't know
 9 whether, if it were utilized in the field, it
 10 would be used with Benzodiazepines, but very
 11 clearly when it's used as an elective situation in
 12 the hospital, it's routinely used with
 13 Benzodiazepines because the hallucinations can be
 14 horrendous.

15 DR. HENRY: Well, let me just say
 16 that protocols are to follow. The first step we
 17 elected to do was to put it on a formulary and
 18 then protocols would be developed, subsequently,
 19 for ground crews. The experience, I would think,
 20 that was shared across the state is that it is
 21 commonly used for procedural sedation in children.
 22 And it is one of the drugs of choice for sedation
 23 for asthmatics who need to be intubated because of
 24 the bronco-dilator effects of the drug. It's

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1 known in adults that it can cause these emergence
 2 reactions in ten percent or so of the patients.
 3 So many of that -- much of that was discussed, but
 4 it is included in most of the difficult airway
 5 courses nationally for EM - emergency medicine,
 6 anesthesia, EMS as one of the drugs with
 7 appropriate cautions. So it's certainly not for
 8 every case, and there are contrary indications,
 9 too, as you mentioned, of people you wouldn't want
 10 to have the increased sympathetic tone. So yeah,
 11 I appreciate that. Anyone else want to discuss or
 12 any other questions? So, the motion is to add it
 13 to the formulary. Okay.

14 (Roll call vote taken.)

15 DR. MARSHALL: One more action item.

16 At the last meeting, or the meeting before, we had
 17 a presentation by the CARES Foundation, who came
 18 and presented issues related to congenital adrenal
 19 hyperplasia and the use of glucocorticoids in
 20 patients with this condition who have -- or an
 21 extremist and the urgency of the need to give this
 22 medication in a timely fashion. They did bring
 23 forward evidence of other areas that are -- have
 24 implemented protocols for the use of

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1 glucocorticoids in patients specifically
 2 identified as having this condition and being an
 3 extremist. We had some discussion about that, and
 4 then we asked the EMS-C committee to review the
 5 issue. They did so, and they came forward with a
 6 recommendation. They looked at the issues on the
 7 use of glucocorticoids in patients with congenital
 8 adrenal hyperplasia and especially in children and
 9 the low numbers of patients in New York State that
 10 this might apply to, and what they came back with
 11 was for certain circumstances, it might be
 12 appropriate to utilize glucocorticoids in these
 13 patients. The issues that they came up with, or
 14 the circumstances that they identified, were one,
 15 that the child must be readily identifiable via a
 16 medical bracelet or other similar means as a
 17 patient with either congenital adrenal hyperplasia
 18 or another condition which presupposes them to
 19 acute adrenal insufficiency or Addisonian crisis.
 20 In addition to that, the child must have one or
 21 more findings typically associated with actual or
 22 impending adrenal insufficiency such as fever,
 23 shock, trauma, altered mental status and
 24 hypoglycemia. Once those things have been

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1 identified, the initial treatment would be high
 2 concentration O₂, normal saline infusion,
 3 intravenous dextrose, if it's appropriate, and
 4 glucometry. After that, then glucocorticoid
 5 therapy would be useful. This would be provided
 6 by an advanced life support provider. The
 7 recommendation is based on several factors. One
 8 is the high morbidity and mortality of the
 9 condition associated with Addisonian crisis and
 10 the fact that there is a low risk for the
 11 medications that would be used. They looked at
 12 and provided recommendations on hydrocortisone,
 13 which is the primary glucocorticoid that would be
 14 used, and methylprednisolone. Most -- a lot of
 15 ambulance services in New York State do carry
 16 methylprednisolone already and paramedics are
 17 comfortable using this medication in the
 18 pre-hospital setting. The EMS-C group also
 19 provided dosage recommendations based upon age.
 20 There were some questions from medical standards
 21 regarding dosage recommendations, and currently -
 22 you know - when we use methylprednisolone, we
 23 could use 125 milligrams. The dosages that EMS-C
 24 is talking about are two to twenty milligrams,

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1 depending on patient age. So at those doses, I
 2 think we are very comfortable in using this
 3 medication. So the committee, medical standards,
 4 recommended accepting the report and
 5 recommendations of EMS-C group along with the
 6 understanding that -- and the EMS-C has been asked
 7 to develop some specific languages -- some
 8 specific language that regions might use if they
 9 so choose to in any protocols that they might
 10 implement for this condition using these
 11 medications. So the recommendation is that we
 12 accept the report of the EMS for Children and move
 13 forward to the regions.

14 DR. HENRY: And I would add, we
 15 asked them to come back and just clean the format
 16 from a narrative to something more familiar we're
 17 looking at, so it's very clear to people. But
 18 their steps were as outlined in the bullets. Are
 19 there any questions? Discussion?

(Roll call vote taken.)

21 DR. MARSHALL: Thank you. The rest
 22 of the -- the rest of the items that I have are
 23 for information purposes. We did have some
 24 discussion on the ALS protocol -- ALS statewide

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1 protocol standards. Sharon Chiumento worked very
 2 hard and developed an outline of draft protocols
 3 that we might use, which includes the basics for
 4 each level of provider and also includes all the
 5 options that all the regions are using. She went
 6 through and she looked at several existing
 7 protocols and put them together in a very neat --
 8 neat package and she worked very hard and I'd like
 9 to thank her for doing that work. These were
 10 e-mailed out, and so we were asking that people
 11 take a look at them and if they have any comments
 12 about the format, to please let us know so we can
 13 work on that over the summer.

14 In addition, there was some other
 15 discussion regarding state standards and what they
 16 are and if it's a protocol or a standard or a
 17 guideline and perhaps state standard might be
 18 something that medical standards could present to
 19 SEMAC, which would be -- the one I used this
 20 morning was the state standard would be that all
 21 BLS ambulances in New York State would have an
 22 AED. So that would be a state standard. So those
 23 are some of the things that we're discussing. I
 24 know there are some that would need law department

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1 -- and I don't know if Mr. Wronski wanted to
2 mention that, where we're going with that.

3 MR. WRONSKI: Yeah, sure, just
4 briefly. This was a meeting with myself, Andy
5 Johnson, the director of house counsel, and Rick
6 Coutante (phonetic), who's the long-time EMS
7 counsel director of EMS --

8 COURT REPORTER: Could you talk into
9 the microphone? I'm having a hard time --

10 MR. WRONSKI: We discussed issues
11 regarding process - protocol process, approval
12 process, state protocol or standard and very
13 specifically to the ability to enforce these, both
14 the regional and state protocols. And they
15 continue to support that the state sets the
16 standard. Whether you call it a standard or a
17 protocol, it is yet to be determined finally, but
18 the regions have the right to develop their own
19 protocols following that state standard but need
20 to be approved at the state level. The -- but
21 house counsel has felt that the issue is of such
22 import to the Department and really to all the
23 regions, because what you write, you expect people
24 to follow. And they want to be sure that the

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1 process you put in place and how you approve it,
2 in fact, can be enforced by you and by us over
3 time. And so they're putting together a small TAG
4 of their own experts to review the law and the
5 process and then will come back to us in the
6 September meeting. They promised me they will
7 have this at the September meeting so that we have
8 a final comment on our process and we can move
9 forward. That does not prevent us, in the
10 interim, from discussing protocols and issues and
11 moving state business forward, but the legal
12 review should be done by the September meeting.

13 DR. MARSHALL: There were a couple
14 other items that we discussed that I think perhaps
15 will come up in Mr. Wronski's report, but one of
16 the things Mr. Delagi mentioned earlier was
17 medical direction, which medical standards also
18 discussed this morning. And we discussed a lot of
19 issues. One was -- the main issue was who
20 provides online medical control in New York State.
21 The state regulations say that online medical
22 control can be provided under the direction of a
23 physician, without really defining what that term
24 "under the direction of a physician" means. And

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1 our SEMAC advisory 9501 says that the provider of
2 online medical control in New York State must be a
3 physician. We've learned through surveys and
4 other avenues in the past several months, and we
5 had those presented at medical standards, that
6 it's not always a physician who is available to
7 provide online medical control and that there are
8 mid-level practitioners that are providing online
9 medical control with physician availability. So
10 we discussed who should be providing, who could
11 provide online medical control, whether it's a PA
12 or a nurse practitioner. We talked about whether
13 the doctor would have to be on premises, on scene,
14 available within thirty minutes. We talked about
15 jeopardizing the standard of care in EMS. We
16 talked about education of the person providing
17 online medical control, regardless of their level
18 of -- of -- provider level, whether they're a
19 paramedic, a nurse practitioner or a physician,
20 what should their education in EMS be. It was
21 pretty clear that when you talk about offline
22 medical direction in a protocol setting that it's
23 the physician that has to be in charge of that
24 process and everybody felt that way. When it

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1 comes to providing online medical control, it
2 seemed like the group was split. We also talked
3 about oversight, just in general, not specifically
4 related to a PA or a nurse practitioner providing
5 online medical control, but just, in general,
6 safety mechanisms that would need to be put in
7 place if you did have a mid-level practitioner
8 providing online medical control. We talked about
9 hospitals willingness to provide online medical
10 control to an area that is not in their catchmen
11 area, whether they have a -- concerns about
12 liability or other concerns that would make them
13 reluctant to provide online medical control for
14 services outside of their region. And we decided
15 that we weren't going to solve this today, so
16 we'll be having several more meetings and
17 conference calls and e-mails over the summer. So
18 I would invite you to submit your comments so that
19 we can include them in any discussions. And
20 that's the end of my report.

21 DR. HENRY: Any discussion or
22 questions for Dr. Marshall? Dr. McEvoy?

23 DR. MCEVOY: I just had a note about
24 a couple things. Was there any recommendation

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1 from STAC about tourniquets? Have you heard
2 anything back from them?

3 DR. HENRY: We did not have
4 discussion at our -- oh, at the STAC meeting? Go
5 ahead. Do you recall specifics on that?

6 MR. WRONSKI: We -- and I apologize.
7 They were jammed themselves. But I did -- we did
8 send a followup to the chair and there is nothing
9 specific from the STAC at this time. I'm going to
10 pursue it again and what I'm going to suggest,
11 actually, to the SEMAC is that we might do some of
12 our own literature search as well for this. The
13 chair did advise that - Dr. Marx - that there has
14 been re-interest in the use of tourniquets because
15 of the military situation and that may be driving
16 some of the reconsideration of the use of
17 tourniquets and how you use them in the civilian
18 sector, but he couldn't point me to a specific
19 article other than there's been several
20 discussions in the use of them in the field in the
21 military operations in Afghanistan and Iraq. So I
22 still don't know that there's been a scientific
23 review that has said, Here's some recommended
24 changes. We did ask, we did follow up, but we

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1 don't have that. So we'll pursue it and I'd ask
2 members here if they have time to look at their
3 own literature searches to see if they come up
4 with any definitive articles on this that changed
5 the thinking. And basically, this all comes out
6 of the national registry changing their test
7 questions to ask them different questions and
8 modify their approach to the use of tourniquets.

9 DR. MCEVOY: I mean, it is -- it's
10 creating an issue with testing now, because at our
11 paramedic level on the practical skills exam, we
12 use a registry sheet, which is very different than
13 any other level that we test at. So we may want
14 to take that issue up here ourselves.

15 DR. HENRY: Would you summarize the
16 change that's driving the discussion?

17 DR. MCEVOY: Well, the national
18 registry changed their sequence of bleeding
19 control to correspond to what's in the
20 pre-hospital trauma life support curricula, which
21 basically says if direct pressure doesn't control
22 it, then apply a tourniquet.

23 DR. HENRY: As opposed to?

24 DR. MCEVOY: As opposed to New York

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1 State curricula, which says direct pressure,
2 elevation, pressure bandage, pressure point and
3 then apply a tourniquet. So -- and I mean,
4 arguably, the evidence that national registry used
5 in pre-hospital trauma life support is arguable.
6 So -- and I think that's the issue.

7 DR. HENRY: I don't think
8 tourniquets have ever been -- they've always been
9 part of bleeding control. It's just whether
10 you're going to use pressure point first and
11 elevation. And the elevation and direct pressure
12 sort of went together. And then you'd try to find
13 that major artery and see if you could block that.
14 So --

15 DR. MCEVOY: If it's a curriculum
16 issue --

17 DR. HENRY: I did the review for the
18 AHA when they did their first First Aid on
19 bleeding control. And there is not a lot of
20 controlled studies on tourniquets. There are
21 studies where people have walked over mine fields
22 and they were not well applied and were
23 twenty-four hours and you wonder how solid they
24 were. And they weren't effective. And there's

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1 studies shown that a -- other studies shown that
2 if there was really good direct pressure and there
3 was really good treatment, people did better. And
4 people can interpret how they want to, but we have
5 certainly, in our own QI in our region, seen cases
6 where there was life threatening bleeding that
7 continued because of lack of tourniquet use. And
8 my colleagues who have returned from Iraq tell me
9 that they are widely used there because there's
10 body armor which shields your torso but the limbs
11 get mangled and the head takes injuries. But
12 they're widely used and I think they're credited
13 with life saving. So I think tourniquets were
14 always taught in EMS for life threatening bleeding
15 that couldn't be controlled where you could apply
16 one.

17 DR. DAILEY: I think it's a little
18 different than that, Dr. Henry. Forgive me for
19 being one that came in the 80s, but until
20 literature started coming back from Afghanistan
21 and Iraq with these recent campaigns in the last
22 eight years, there really was nothing out there
23 that had ever told me it was okay to use a
24 tourniquet. And now, very clearly, we are seeing

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1 tourniquets appearing again and again in
 2 literature. Military literature very clearly
 3 demonstrating that they have changed. Early in
 4 the war, they were beginning -- they were having
 5 significant number of people die in isolated
 6 extremity wounds and that's just not happening
 7 now. I think it comes a little differently for
 8 us, too, because if you are going to use elevation
 9 and direct pressure, you need to be right over the
 10 patient. You need to be unsecured in the back of
 11 the ambulance when you've got a critically ill
 12 patient. This, to some extent, comes back again
 13 to provider safety, as well, where you control the
 14 bleeding and you no longer have as acute a
 15 situation, driving can slow down. Everything
 16 becomes much, much safer. We certainly are using
 17 them in our trauma bay right now with very great
 18 success.

19 DR. HENRY: To draw blood?

20 DR. DAILEY: To draw blood. Big
 21 veins. We are using them with great success on
 22 isolated extremity injuries. And I agree with
 23 Mike. I think this is something that we can't --
 24 I don't think we're going to see a double blind

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1 placebo controlled study on this. I think we have
 2 to accept what the military has taught us as they
 3 backtracked and said, No, these are the things to
 4 do.

5 DR. HENRY: It's like the reports
 6 that came when they were teaching lay people.
 7 Well, you're going to use wire and you're going to
 8 mangle limbs. And - you know - those anecdotes
 9 kept perpetuating, too, that I don't see in the
 10 literature. And there was a fear away from that.
 11 There was a scare away from that. And that got
 12 actually pushed out of it. That sort of
 13 negativity -- that spread, I guess, but my
 14 recollection is they were always in the
 15 curriculum. Tourniquets were the last resort, but
 16 they were still there. They existed, but I guess
 17 were pushed away. But I know in our county, our
 18 techs sent a message out to providers to remind
 19 them they could be useful back years ago after
 20 some review. And I think that is a general
 21 consensus. So if there is negativity on using
 22 them in the State, I think we needs to correct it,
 23 whether it comes from SEMAC -- I guess that's your
 24 question, right?

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1 DR. MCEVOY: We might want to refer
 2 it to education and training, since it's now
 3 clearly a difference in practical skills exams at
 4 different levels. One uses the registry, the
 5 other three don't. So a paramedic has a whole
 6 different way of controlling bleeding than any
 7 other provider in New York State.

8 DR. HENRY: Right. Well, that
 9 doesn't make sense. And I hear what you said and
 10 I thought about with patient safety -- provider
 11 safety issues, how do you -- and what are the
 12 situations where you could be unbelted in a rig?
 13 Well, uncontrollable bleeding would probably be
 14 one that might justify if it was life-threatening.
 15 You're taking a risk yourself, but if you could
 16 control it with a tourniquet, why would you
 17 subject yourself? I think we need to work on
 18 this. I think we should tackle this and look at
 19 the confusion on a piece of paper and make some
 20 recommendations as a group.

21 DR. MCEVOY: The other question I
 22 have for Dr. Marshall was, there was a set of
 23 skills and procedures that got sent to medical
 24 standards about things that can or can't be

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1 performed in the back of a moving ambulance and
 2 that was going to come back to safety, I think.

3 DR. MARSHALL: We didn't talk about
 4 that today. There was a grid that was developed
 5 which talked about that. I'll make sure we get
 6 that sent out again and come back to that.

7 DR. HENRY: Dr. McEvoy, were there
 8 any action items from the education meeting today?

9 DR. MCEVOY: Yes. I apologize for
 10 my appearance. I was nearly malled by the
 11 education and training committee when I gave a
 12 report from the finance committee about funding
 13 for courses, but we'll talk about that later.

14 One motion that comes forward from
 15 training and ed is to allow one hundred percent of
 16 the core content in a refresher program to be
 17 completed online and for education and training to
 18 establish a TAG that would create standards for
 19 that and a content approval process. So,
 20 essentially, this has been an ongoing discussion
 21 at education and training about how you complete
 22 the recertification when you do it through the
 23 continuing ed process and whether you can complete
 24 that online or offline. Presently, a very small

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1 amount of it is permissible to be done online.
2 This would increase that allowance.

3 DR. HENRY: What is the reasoning
4 behind this, if you could?

5 DR. MCEVOY: The reasoning is that
6 there have been a number of demonstration projects
7 that have gone up to a hundred percent of it being
8 completed online and been very successful. It
9 also makes it easier to facilitate the completion
10 of it by providers, because the online process
11 tends to be something that they prefer a little
12 bit more than having to physically go somewhere in
13 order to fulfill that content. And it appears if
14 it is well controlled and the quality is there,
15 which I think we're at that stage where we can do
16 that, that you accomplish the same ends by using
17 online as much as you can by having a person
18 physically in a classroom.

19 DR. HENRY: Questions? Discussion?

20 DR. GOODMAN: Would there be a
21 practical component that would have to be done
22 live?

23 DR. MCEVOY: There is no practical
24 component in the core content, but that is part of

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1 the requirement, which still would need to be done
2 live, yes.

3 DR. HENRY: Any other? All right.
4 All in favor of the motion, raise your hand.
5 Opposed? Abstentions? Okay. Carries.

6 DR. MCEVOY: Just in quick summary,
7 there was a couple of memos that came out from the
8 bureau. There's a new -- a revision to the
9 funding memorandum, which doesn't change the
10 funding rates but talks a little bit about
11 requirements for core sponsors. There was a
12 revision to the criminal conviction memo, which
13 basically emphasizes that people who come into a
14 course with a criminal conviction, that allows
15 them not to be able to sign the student
16 application -- should not be tested at any level
17 prior to being cleared by the bureau. And there
18 was some continuing discussion about folding the
19 new curriculum into the current certification
20 process and that's a work that's in progress at
21 different levels with different TAGs.

22 There was a discussion about
23 strokes, and I think Mr. Wronski will probably
24 talk about this, but there was a meeting that

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1 suggested that in New York State, people are not
2 getting TPA when they present to stroke centers or
3 to non-stroke centers with the regularity that
4 they could be getting that and what the education
5 committee could potentially do to encourage EMS
6 providers to be a little bit more aware of
7 patients who are having strokes, screening them in
8 the field and making earlier notification at
9 hospitals. So education and training is going to
10 work on that a little bit.

11 A booklet came out from the Office
12 of Mental Retardation and Developmental
13 Disabilities on autism.

14 DR. HENRY: May I ask a question on
15 that?

16 DR. MCEVOY: Sure.

17 DR. HENRY: So what information did
18 you have about stroke -- what are they
19 interpreting the patients as having?

20 DR. MCEVOY: What EMTs are
21 interpreting? I think they are missing patients.
22 So essentially what they're saying is people
23 present to a stroke center who are eligible for
24 TPA based on their criteria and their CT and

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1 they're getting it four and a half percent of the
2 time. People who present at non-stroke centers
3 are getting it 2.7 percent of the time when
4 they're eligible for it. And mind you, the
5 national average is four percent, so this is a
6 little bit better in our stroke centers than being
7 done nationally, but still it's lower than a
8 hundred percent.

9 MR. WRONSKI: And there is a variety
10 of reasons, which probably varies depending on the
11 hospital and EMS systems. In some cases, EMS
12 brings in a case without pre-notification at the
13 hospital, and when they bring the patient in, they
14 haven't necessarily identified that this is
15 clearly a stroke patient. The ED -- a patient may
16 walk in and be in the ED. These aren't all
17 necessarily EMS patients. The patient may walk in
18 and be some time before they're identified. If
19 enough time goes by, TPA may not be appropriate
20 any longer. And there were a variety of other --
21 and I can't recall them offhand, but there were a
22 variety of other reasons why some patients are
23 missed. And one of them is public education. A
24 lot of people wait too long to react to what's

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1 going on to them. They don't know what it is, and
 2 different from cardiac, chest pain, they haven't
 3 been trained to immediately respond to that. So
 4 that's part of what's missing, as well. You put
 5 all these factors together and I was at the
 6 conference and I was kind of struck by the very
 7 low percentage of people who actually are getting
 8 TPA. And potentially, if everything had worked,
 9 from the patient to EMS to ED to the stroke team,
 10 I would have thought it would be a much higher
 11 percentage, but it's actually quite low.

12 DR. HENRY: Dr. Broderick?

13 DR. BRODERICK: So as I understand
 14 it, we're talking about all stroke patients. The
 15 denominator is all stroke patients, not all
 16 eligible stroke patients?

17 MR. WRONSKI: I think it's all
 18 eligible. All eligible --

19 DR. BRODERICK: So everyone that
 20 comes to the ED under three hours?

21 MR. WRONSKI: No. Eligible being
 22 that had -- and I believe this -- and I'll have to
 23 double check. We can bring you back more
 24 information next time, but I believe it included

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1 patients who, had they, at the time of their
 2 symptoms, realized what was going on or suspected
 3 they need to get to a hospital, would have left
 4 sooner for the hospital or called EMS. And I
 5 believe they're in that factor.

6 DR. MCEVOY: It was the AHA
 7 criteria, the three-hour window and the other
 8 screening, the CT that was negative for a bleed.
 9 So it is eligible patients, basically.

10 DR. HENRY: I think we'd be
 11 particularly interested, if it's available, to
 12 hear about patients who did enter EMS, what the
 13 call time was, what they told the dispatch
 14 operator that their symptoms were, what EMS found,
 15 how good our, quote, Cincinnati screen is. I
 16 think it would be very interesting to us.

17 DR. YOUNG: The biggest piece of the
 18 data is two-fold. One is that only forty-three
 19 percent of all stroke patients are not getting to
 20 the primary stroke centers, even now. So you got
 21 almost a 50/50 chance of being transported to a
 22 primary center. And the other piece that they
 23 found, they did a study in Albany, Deb Spicer from
 24 the Department actually did a detailed public

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1 education study and they found that the best way
 2 to get the message out, because, again, most
 3 patients, including some very educated people, one
 4 case actually occurred during one of our meetings
 5 in a room full of neurologists and neurosurgeons,
 6 one of the individuals was having a stroke and
 7 didn't recognize it. You know. It's not like
 8 chest pain, you can recognize chest pain. A lot
 9 of folks that undergo strokes, when you talk to
 10 them afterwards, I think as most of you know, they
 11 didn't know what was going on. Well, I was a
 12 little weak. I was tired. I just wasn't quite
 13 myself. They can't appreciate what's going on.
 14 So public recognition on the part of the families
 15 and folks that are with the patients is going to
 16 be key. But what they found in the Albany study
 17 was the only thing -- they tried television, radio
 18 spots, they put up billboards, they put up posters
 19 on public transportation areas such as bus
 20 terminals. The thing that actually worked was the
 21 television spots, but that also was the most
 22 costly. Now, they are rolling something out in
 23 the central New York region, as well, because they
 24 have some grant money for that, so we'll see how

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1 that goes. But preliminarily, we think that's
 2 where the biggest bang for the buck is going to
 3 be.

4 DR. HENRY: I think we cut you off
 5 from your last -- or one of your --

6 DR. MCEVOY: I'll just mention. The
 7 finance committee asked me to go to systems and to
 8 training and ed and just give some preliminary
 9 ideas about readjusting the course funding rates,
 10 and that met with a flood of rotten tomatoes and
 11 eggs from training and ed and suggestions that I
 12 may need a trauma center from systems, but we'll
 13 hold off on the details of that until September
 14 when we get some commentary back from those two
 15 groups.

16 DR. HENRY: Thank you. Any other
 17 questions or discussion on the report from Dr.
 18 McEvoy? Okay. Hearing none, Mr. Wronski could
 19 you give the report from EMS bureau?

20 MR. WRONSKI: We've covered most
 21 items. Just briefly to go back quickly to stroke,
 22 to finalize. There was a American Heart
 23 Association sponsored and Department of Health
 24 sponsored stroke conference in Westchester --

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1 COURT REPORTER: I'm having a hard
2 time hearing you. I'm sorry.

3 MR. WRONSKI: -- stroke conference
4 in Westchester, in White Plains actually at the
5 Crowne Plaza and Dr. Young was there as were other
6 people from the department. And it was very well
7 represented by hospitals from various areas of the
8 state and there were speakers ranging from expert
9 surgeons who treat the stroke surgically to public
10 health nurses who talked about how to get public
11 education out there and get the public better
12 aware of recognition of strokes and the need for
13 that. I will copy a variety of materials that I
14 had picked up at the conference, which I'll share
15 with the SEMAC over the summer so you can see some
16 of the materials. Dr. DeRobertis from the Hudson
17 Valley actually gave a presentation regarding EMS,
18 and one of the things in questions and answers
19 that really became obvious to me, and at one point
20 they dragged me to the podium to talk a little bit
21 in answer to some of those questions, is a lot of
22 hospitals, stroke centers and non-stroke centers,
23 but particularly the hospitals who are running
24 stroke programs don't necessarily understand their

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1 local EMS system. They wanted me to order all the
2 dispatch centers to - you know - adopt certain
3 algorithms for stroke, and I said, "Well, that
4 would be great. I'd love to do that. When are we
5 going to write that law?" And I will tell you
6 that I met privately with some advocates for
7 improving stroke response and they talked to me
8 about what they could say to the legislature. And
9 I will tell you for the record, and to the
10 dispatchers who don't like me to say this that
11 it's about time that there was a law in this state
12 that said that dispatch centers need to be EMT
13 trained - all right - they need to be 9-1-1 and
14 they need to agree to work with their local REMAC
15 in incorporating the regional protocols into their
16 algorithms locally, so when they dispatch, they
17 very well understand what you're doing medically
18 in your area. And - you know - so I said that and
19 you should say that locally. And what I said to
20 the hospitals is that if you want to get the
21 dispatch center to modify some of its behavior, if
22 you don't think it's screening the patients well
23 enough, go visit them. I said in a couple
24 instances I know in the past, hospital CEOs

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1 invited the dispatch center director or the county
2 executive or the town executive, wherever your
3 dispatch center is, to the hospital and you sit
4 down with them and you talk to them and you tell
5 them why this is important and sometimes that
6 works. So sometimes there is a little solution
7 while there is not currently a state solution to
8 this. But they did ask. That was a concern for
9 them. One of their other things they underlined
10 on EMS was that many of them are experiencing no
11 calls from the ambulance prior to bringing the
12 stroke patient, and that when they get there, EMS
13 is saying, I've got a stroke patient, or I think I
14 do, but they haven't called in advance. I think
15 what that is, in most cases, it may be a BLS unit
16 that's bringing the patient and they're not used
17 to calling up ahead in all cases, or they call a
18 few minutes before getting to the hospital. It's
19 very important from the hospital's perspective,
20 the stroke center's perspective, to call as early
21 as possible to your knowledge that this could be a
22 stroke patient so they have time to get the stroke
23 team together. And that was underlined for me by
24 them. Again, it was a good conference. I think

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1 it was well rounded and I will have the materials
2 copied and sent to all of you so that you can take
3 a look at it.

4 I'd like to thank those of you who
5 could attend and those of you who had our support
6 for the EMS memorial this year that was held. It
7 was very successful. There were two individuals
8 added to the memorial and the family members were
9 very appreciative. And the Commissioner came and
10 spoke at that and there were actually quite a few
11 legislative members who came to this particular
12 event and we thank them for coming.

13 The biggest event, and we'll talk
14 about it at the disaster preparedness meeting, but
15 the swine flu. And swine flu has mixed reviews.
16 You know. Everybody was afraid of the swine flu
17 and -- but everybody really didn't need to be
18 quite as afraid as they became. And this was a
19 learning lesson. It's one that we already knew
20 from prior history that one of the biggest
21 problems when you have, particularly, a microbe is
22 that people are afraid of it. And here's a new
23 microbe. We've had them in the state. I've
24 forgotten all their names, but one of them came

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1 from Cuba, didn't it? Or we thought it did.
 2 Somebody claimed it came from Cuba. I take that
 3 back. I don't know if it did. The -- but the
 4 bird -- West Nile virus, thank you, and it's not
 5 to say the West Nile virus isn't dangerous, but
 6 the idea was that everybody in the bureau of
 7 Queens was going to die in the next few days if
 8 they went outside during any part of that virus
 9 and that was silly. That kind of happened here.
 10 The public got very alarmed, and in part, maybe
 11 some EMS systems did, too. But we do have to take
 12 caution because you learn from the worried well,
 13 they have overwhelmed some of our hospitals and
 14 continue to do so, actually, in parts of New York
 15 City where schools have closed down, where EDs
 16 have doubled their volume in some cases, and tents
 17 have been setup outside of some of the hospitals
 18 at one point to screen patients coming in. And
 19 this affects everybody and it affects -- it
 20 affects all patients. But there is a legitimate
 21 worry and there's a legitimate worry when you
 22 don't know what you're dealing with initially and
 23 public health and the scientists are trying to
 24 evaluate it. And, of course, no one knows exactly

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1 where this is going to in the fall and whether
 2 it's going to come back more dangerous than it
 3 first appeared. For our purposes, we have to
 4 study how EMS responded, how we can improve that
 5 response. We did learn that many, many, many
 6 ambulance services don't carry N95s. Our
 7 recommendation is don't wait for the next bug.
 8 Carry at least a limited supply in every ambulance
 9 service so that you have a -- an ability to
 10 respond immediately until such time as other
 11 supplies can get to you. We were -- we were a
 12 little bit amazed at how many ambulance services
 13 do not carry N95s routinely. So anyway, we saw
 14 this as a learning lesson. We're going to study
 15 it some more, discuss it inhouse. You should do
 16 that locally. We'll discuss it a bit more at the
 17 disaster preparedness meeting.

18 I did mention the overcrowding
 19 letter that went out from Jim Kline, the director
 20 of OHSM to all hospitals indicating that the
 21 Department will be getting this year some focused
 22 reviews of hospitals to take a hard look at how
 23 they're dealing with overcrowding, see if we can
 24 identify best practices and share them with

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1 people. That will begin this year. We are
 2 already using data to evaluate some hospitals and
 3 identify hospitals we should visit.

4 One other item, office-based
 5 surgery. I'm sorry Dr. Morley is not here now.
 6 I'd have him talk in more detail. I don't know if
 7 Greg knows more about this, but the office-based
 8 surgery regulations now require -- and they'll be
 9 effective, I think it's July 14, yeah, July 14th
 10 -- all office based surgery centers who use
 11 moderate anesthesia must be licensed by July 14.
 12 And they should have put in their application
 13 already so that by July 14th, they're approved.
 14 If they conduct procedures in their office and
 15 they have not been licensed and they're using
 16 moderate anesthesia, it's illegal. And what will
 17 happen to surgeons who practice in that
 18 environment is they will be sent to the office of
 19 professional medical conduct for a disciplinary
 20 hearing. I'm sending that with you so you can
 21 share that with everyone you know and you're aware
 22 of it. Your responsibility as working in a
 23 hospital is that if a patient comes into you whose
 24 had problems coming out of an office-based surgery

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1 and there is a report requirement that is required
 2 of hospitals. And primarily it's to identify
 3 quality of care issues. It's also to identify
 4 scofflaws. Office-based surgeries that have not
 5 applied for the license which requires certain
 6 standards and we hope that through the reporting
 7 mechanism through hospitals that we'll identify
 8 some of the places that have not applied to the
 9 department and are meeting standards. So that's
 10 an update for you.

11 DR. DAILEY: Mr. Wronski?

12 MR. WRONSKI: Yes.

13 DR. DAILEY: When that actually was
 14 first brought out, there was some concern because
 15 of the way the regulation required reporting of
 16 adverse events in office-based surgery was
 17 written. It says that any physician, I believe --
 18 forgive me for being inaccurate, but any physician
 19 who becomes aware of that must report or they are
 20 committing misconduct.

21 MR. WRONSKI: Right.

22 DR. DAILEY: Has that been eased up
 23 on the hospital end -- the hospital itself, or
 24 would that mean the emergency physician who first

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1 sees the patient, the admitting surgeon in the
2 hospital, any consultant physician in the
3 hospital, every single one of them would be
4 responsible to report to the Department?

5 MR. WRONSKI: I'm going to ask Greg
6 to answer that, because I don't know the answer.

7 DR. YOUNG: The way that's been
8 handled is the hospital that you're working at,
9 you wouldn't need to make your own separate
10 report. If you identified a case that had a bad
11 outcome, it's sort of like the case of suspected
12 child abuse. We're mandated reporters in the
13 emergency department. What you should do is
14 contact your hospital quality improvement
15 committee or whatever you use to file reports.
16 You don't actually have to make the report
17 yourself, and I would encourage you not to, but to
18 go through your normal reporting mechanism. Let
19 them make the report. That will then meet your
20 need and that will prevent the surgeon and whoever
21 else subsequently follows that wouldn't make the
22 same report. It's a way of checks and balances.

23 DR. DAILEY: I certainly understand
24 that. I would just worry about the risk to

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1 individual physicians. Thank you.

2 MR. WRONSKI: Dr. Fairbanks?

3 DR. FAIRBANKS: I just want to add
4 two question. One is, how do we know whether an
5 office is certified or not? And with respect to
6 your question, does EMS have a reporting
7 requirement or is this just the physician in the
8 hospital?

9 MR. WRONSKI: EMS isn't included in
10 the reporting requirements. That does not mean
11 you shouldn't. If you believe that something is
12 awry in this particular clinic and you're getting
13 a frequent flyer to the clinic or the EMS system
14 and you're picking up patients all the time, well,
15 it's a question, but they're not required.

16 DR. FAIRBANKS: If my agency -- I'm
17 sorry. If I'm an agency medical director and I
18 have an agency that frequently sees patients, but
19 I don't become aware of it, should I have had a
20 process in place in my agency to become aware of
21 it? I mean, how crazy is this?

22 MR. WRONSKI: No. No. It doesn't
23 -- it doesn't specifically ask you to do that. I
24 think you have to use your own judgment when you

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1 get certain information whether or not you have a
2 suspicion, and a good suspicion that something's
3 wrong and maybe then you would, as a medical
4 director, work with your hospital to see if there
5 is issues there before you reported anything. But
6 one of the ways the Department has historically
7 found out about bad practices in an office setting
8 has not just been through patients but through
9 hospitals who were tired of taking care of
10 patients who were, frankly, being killed and were
11 showing up in their EDs. And I know that because
12 I ran the PMC program in New York City and that's
13 how we got a lot of our cases.

14 And actually just one last comment.
15 When a physician or a nurse sends us information
16 and the department, particularly when I worked in
17 PMC and it was usually ninety percent accurate
18 that this was a real problem. When a patient did
19 that, it was more in the one to two percent area,
20 but they really didn't understand necessarily the
21 medical care, but you do.

22 Another item, one which I'm
23 delinquent on, but one in which I have promised to
24 get out before the next meeting. I have had a

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1 meeting with HANYS and with hospital services and
2 I promised a letter that would go out from us,
3 hospital services and myself, to hospitals
4 encouraging their support of training and opening
5 their doors for training for EMS, because we heard
6 some concerns in some areas that hospitals are not
7 as friendly these days with allowing EMS training
8 to go on within its facility and these are the
9 approved training courses where sponsors teach
10 them. And they need to have programs within the
11 hospital setting. So we'll encourage that and I
12 will work on that letter and get that out. And
13 hospital services director indicated to me
14 previously that she'd be willing to co-sign that.

15 The last thing, and I apologize to
16 Lee Burns, who has now left to go to Washington to
17 fill in for our EMS-C grant. Either myself or
18 assistant director needed to be at the grant, and
19 I couldn't be there, so I sent Lee. And part of
20 the reason I sent her there is that now I've been
21 formally advised that Lee is now the acting deputy
22 director for the bureau. And so there's no way
23 that on any routine basis, I can manage this
24 bureau without some assistance and Lee's been

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1 giving me that assistance. And now formally she
2 is the acting deputy director of the bureau and I
3 wanted to notify you and I'll be notifying the
4 SEMSCO about that. And so -- and I'm sure she's
5 up to the job after many years. This is voluntary
6 on her part. I asked her if she wanted to do it
7 and she said "no."

8 DR. HENRY: Wise woman.

9 MR. WRONSKI: But just like she
10 didn't want the job of director of operations when
11 she said "no," I convinced her. But really, she
12 gave it some careful thought. She knows what's
13 involved and she's very happy to do this and is
14 pleased to work with you and others.

15 DR. MCEVOY: We know you offered her
16 chicken wings.

17 MR. WRONSKI: I may have done that.
18 She'll be -- she'll be very good at what she does.
19 She knows all of you and your issues and concerns,
20 and they are hers, because she works in the system
21 just like you do.

22 DR. HENRY: We wish her well and
23 look forward to working with her.

24 MR. WRONSKI: That is my report.

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1 Any questions?

2 DR. KUGLER: Just a quick question.
3 Is somebody backfilling Lee, or is she doing both
4 jobs?

5 MR. WRONSKI: She -- Lee is an
6 amazing woman. She's going to do both jobs, and
7 -- but clearly over time as she assumes more and
8 more of the deputy's role, we'll try to find
9 assistance for Lee -- but right now it is a dual
10 job as the Governor told us and the prior Governor
11 and the Governor before that. I think three of
12 them have told us now to do more with less.

13 DR. HENRY: Dr. Olsson?

14 DR. OLSSON: Just to clarify for
15 myself. The letter about support for hospitals,
16 you're referring to new courses as opposed to
17 going back for remediation or in-training? We had
18 that discussion always.

19 MR. WRONSKI: Right. This one is
20 for anything done through an approved sponsorship
21 -- I forget the details. Any approved sponsor who
22 is providing the training. And typically we have
23 an agreement with a hospital, and now there are
24 some closed doors going on there. We're going to

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1 ask them to try and open the doors and work with
2 the sponsors. There will be -- and I didn't put
3 this in my report -- but we will be trying to put
4 a group together to includes HANYS and some others
5 to discuss the bigger issue, which is ongoing
6 training in the hospital, the presence of EMS
7 providers in the hospital, but that's a much
8 larger issue. But we're going to take little
9 nibbles at it and start with that letter.

10 DR. HENRY: Dr. Broderick?

11 DR. BRODERICK: One last thing, just
12 to clarify about the moderate sedation and PMC
13 issue. So if we get a patient from a outpatient
14 facility that had outpatient surgery, we would
15 simply report it to the state and they will look
16 into see whether or not they're licensed or not?
17 That's really our -- what we're looking to do?

18 DR. YOUNG: No. What we're looking
19 for is adverse outcomes. So if you have a patient
20 that has had an adverse or unexpected outcome
21 following office-based surgery, we're trying to
22 get a handle on that. We'll worry later about an
23 RN who is licensed on our end, who was licensed,
24 who isn't. We're not asking you to try to figure

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1 out if facilities are licensed or not. That's not
2 the issue.

3 DR. BRODERICK: Right. I'm saying
4 by virtue of being in the ED, I'm going to assume
5 they had a bad outcome. Otherwise, likely, they
6 wouldn't be here. I mean, that's bothersome. Say
7 they have severe pain from that. Is that an
8 adverse outcome? You know what I mean? I just
9 want to know what our reporting duties will be. I
10 assume if somebody comes in from outpatient
11 surgical that are into the ED, largely that's an
12 adverse outcome. Certainly, the surgeon or anyone
13 else didn't anticipate that.

14 DR. YOUNG: That's a reasonable
15 assumption.

16 DR. BRODERICK: Okay.

17 DR. HENRY: Lexicon is used for this
18 when the word "moderate" is used. There's a lot
19 of terms in sedation - conscious, moderate, deep,
20 procedural. Is there a definition used with this?

21 DR. YOUNG: That I don't know, Mark.
22 I assume there is, but I don't know. I haven't
23 seen it. I mean, they assume -- in the hospital
24 call moderate, interestingly, because we are using

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1 more sedation in the pre-hospital setting that
2 isn't presently being monitored quite the same
3 way.

4 MR. WRONSKI: What I would say is
5 that the issue of the use of moderate sedation is
6 the office-based surgical practice. They have all
7 been sent letters and information about
8 office-based surgery and what the requirements
9 are. I think there is more information in there
10 about what moderate means, but the requirement
11 really is if you -- if you've got an office based
12 practice and you're doing surgeries and you're
13 using anesthetics and there is any sense that it's
14 a moderate anesthetic and you're not sure, there
15 are avenues to get that clarified as the
16 office-based practice. You call the department
17 and talk to office-based surgery about this. And
18 they can tell you whether or not they believe what
19 you're doing means you need to apply and get
20 approved, but that information went out in a
21 variety of avenues to physicians across the state
22 and we're hoping that the office-based practice
23 that do these procedures are registering. But the
24 key here for the emergency -- for the hospitals is

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1 really the adverse outcomes and then we'll
2 determine later if a place was a licensed place or
3 not.

4 DR. YOUNG: The usual clinical
5 definition would be something like not conscious,
6 but they can manage their own airway without
7 assistance. I mean, that's what we generally
8 consider moderate. If they need assistance with
9 airway control, then it's a deep level that
10 shouldn't be done.

11 DR. HENRY: All right. Any
12 questions? Any further questions or discussion?
13 Dr. Fairbanks?

14 DR. FAIRBANKS: Just for the DOH
15 report. Apparently, according to my program
16 agency director, there is an announcement to the
17 program agencies about the budget won't be
18 available for three months. If that's true, can
19 you talk about it since it will affect our program
20 agencies?

21 MR. WRONSKI: That the budget won't
22 be available?

23 DR. FAIRBANKS: The word I got was
24 the state can't sign off on the contracts for

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1 three months so we won't be able to be reimbursed.

2 MR. WRONSKI: It's news to me.

3 DR. FAIRBANKS: If it's not
4 accurate, you can disregard my comment. I would
5 think you'd know what it was, so --

6 MR. WRONSKI: Well, I do know there
7 is delays in contract approval in some cases
8 because of sign off of funding being released. It
9 is not so much budget -- I mean, it's related to
10 the budget, but the way the state budget works is
11 that there is a release of funding for use by
12 different agencies on a periodic basis. They give
13 you a chunk. And even after the state budget is
14 passed, there has to be a certification and we're
15 giving you X amount of money to use this quarter
16 based on your expenditure plans, etcetera,
17 etcetera. And sometimes that's delayed. That may
18 be delayed at the moment. I don't know that -- I
19 haven't heard the specific three-month period, but
20 if you talk to me later or have your program
21 agency director, I'll follow up on that and find
22 out if that information is accurate, because I
23 don't have anything that specific myself. One of
24 my staff may, though, and I may not know it.

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1 DR. MCEVOY: You better refer that
2 to Lee Burns.

3 DR. HENRY: Any unfinished business?
4 Good to see we're current. Any new business? Dr.
5 Dailey?

6 DR. DAILEY: Just a brief
7 announcement. New York State ACEP is going to be
8 conducting an EMS medical director's course July
9 7th and 8th in association with their scientific
10 assembly at the Sagamore. Any physicians in New
11 York State are welcome to attend and encouraged to
12 attend. We should have paperwork available either
13 in the back of the room, online at the New York
14 State ACEP website or anybody can feel free to get
15 in touch with me. Thank you.

16 DR. HENRY: I would encourage all
17 the regions to promulgate this -- the availability
18 of this course. You can look at yourself and it
19 represents Monroe county, Albany flight, medical
20 directors, New York City, REMAC experience. The
21 topics go from dispatch through QI, legal
22 components, practical components. This is what we
23 were talking about earlier, people's knowledge, so
24 I think to have such a rich offering in a

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1 beautiful setting, we should take advantage of it
2 and we should encourage our colleagues who have
3 the ability to get people released for a day or
4 two to go, take advantage of it. Yes?

5 DR. GOODMAN: Sometime in February,
6 our facility received a letter from New York State
7 Department of Health with regards to changing the
8 criteria for stroke center benchmarks from zero to
9 three hours to include patients from three to
10 twelve hours. I have two concerns. One is there
11 is not much in the way of robust scientific
12 literature out there to support this three to
13 twelve hour benchmark, and was there consultation
14 with the emergency medicine community and EMS or
15 bureau, in particular, with regards to this? And
16 then what are the implications of the EMS system
17 and our decision we have to make at the regional
18 level with regards to referring patients who
19 present possibly with TIAs with no symptoms at the
20 eleventh hour and diverting these patients or
21 sending them to a regional stroke center?

22 MR. WRONSKI: I'm going to let Dr.
23 Young answer most of that. I'm going to answer
24 quickly on the -- quickly on the EMS. I was

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1 spoken to about the timeframes, and I said, of
2 course, my ambulances would love to take twelve
3 hours to transfer somebody from Buffalo to New
4 York City stroke centers or something like that,
5 if they needed to, but there was no suggestion
6 that EMS itself would be under a new timeframe.
7 There was some discussion about what if we moved
8 in that direction at some point, but -- if the
9 literature supported it, but there was no -- no
10 understanding that the EMS protocol would change
11 from what it currently is. But Dr. Young, maybe,
12 could speak to why they sent that letter and the
13 discussions so far.

14 DR. YOUNG: There actually has been
15 extensive discussion. The whole concept of the
16 stroke center, we have to get people's mindsets to
17 thrombolytics. There is much more to stroke than
18 a simple thrombolytic bolus, and there are a lot
19 of other procedures that are FDA approved but not
20 necessarily met the standard of care -- the
21 stents, the whole nine yards. So I can assure you
22 that there was at least one ED doctor that was
23 very vocal that you may know and may not know,
24 that expressed concerns about extending the

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1 window, because their proposal was for a
2 twenty-four hour window. However, after
3 discussion, it was brought down to the twelve-hour
4 window with the idea of not necessarily -- there
5 have been a lot of misunderstanding of activating
6 the stroke system. It was never the intention of
7 the Department or the stroke advisory physician's
8 work group to say that you get a stroke patient
9 that meets X number of hours that you have to
10 bring in each time the stroke team. The ED
11 physicians are an active part of the stroke team,
12 and as long as there's an evaluation of the
13 patient and they get a rapid CT scan, at that
14 point, you can -- depending on what you find, you
15 make that decision. I need to activate the team
16 or I don't. What we have seen, based on the data,
17 and there are three of us that have looked at all
18 the data and we presented it actually at the
19 stroke conference and looking at some of the
20 outcomes, were there was a mindset that after
21 three hours, they just were treated like a
22 standard patient. This was at a stroke center.
23 We had several significantly bad outcomes, and
24 these are patients that had bleeds that could have

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1 actually been salvaged by transferring down to the
2 center that had endovascular or at least
3 neurosurgical ability. So there are a lot of give
4 and take. The group recommended twelve hours and
5 we put that out. We had the issue come up, and I
6 fielded the questions at the stroke conference and
7 there were over 320 in attendance, and there was a
8 concern that this was going to -- you know -- impact
9 the system negatively. So we're taking it back to
10 the neurologists, neurosurgeons that make up this
11 advisory committee. It's very similar to the
12 cardiac advisory committee for further study.
13 It's also very interesting. During the
14 conference, we came back and we seen that based on
15 one study, E-Cast-3, heart has now taken the four
16 and a half hour window that we had already decided
17 as a physician advisory group and as a state we're
18 not going to mandate, but we're going to leave
19 open the clinical options and change it to a
20 category 1B. So it looks like we have to
21 reconsider it, but I don't think there will be any
22 major change coming from that viewpoint. So,
23 again, the way the system is set up is, what we
24 want to see if you are a designated center, which,

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1 again, is a volunteer designation process, but if
 2 you are going to be a center that we expect that
 3 the stroke patients we'll be seeing and obviously
 4 we triage them. If you have a cardiac arrest or
 5 acute GI bleed or shock or something, they may not
 6 be the first one you'll get to see, but you'll
 7 triage them as best you can. But you'll get a
 8 fairly rapid ED avail, CT scan, and at that point,
 9 then you make what sort of decision, if you need
 10 to, bring in your stroke team. If not, maybe you
 11 need to transfer them to a center that can do
 12 these other procedures, etcetera. So that's the
 13 background. So yeah, there was pretty significant
 14 ED input on that, and EMS was not impacted, to my
 15 knowledge. That was not the intent.

16 DR. HENRY: If you go back in the
 17 archives, when we discussed this the first time,
 18 it was the view of the SEMAC that three hours was
 19 too short. There was a TPA window. And the data
 20 showed that there was almost as many bleeds as
 21 there were people that qualified for TPA. And
 22 part of the advance of having the protocol was
 23 having 24/7 CT availability in more facilities and
 24 having neurosurgical transfer agreements. So some

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1 people could get - you know - rapid triage. So I
 2 think it would be useful, actually, if at medical
 3 standards or maybe for the whole committee, if
 4 there could be an update on availability of
 5 services, rather endovascular or what the thinking
 6 is now for FDA approved treatments for SEMAC, just
 7 to help with protocols and educationally.

8 DR. YOUNG: That's a very --

9 DR. HENRY: If you can facilitate
 10 that for us --

11 DR. YOUNG: Dr. Henry, you must have
 12 a psychic ability, as well, because as we speak,
 13 we finished a survey that is going out to all
 14 designated stroke centers as we look towards what
 15 may be comprehensive centers. It makes sense to
 16 have comprehensive centers and primary stroke
 17 centers, the same way we do regional and area
 18 trauma centers. That is -- it's going to come up
 19 in the brain attack coalition questionnaire, which
 20 some of you may have seen. It's like maybe eight
 21 or ten pages. It's a huge document that is going
 22 to be sent out. We tried to abbreviate and
 23 eliminate the redundancies to see what's out
 24 there, and once we see what's out there, then we

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1 really want to take a hard look at the designation
 2 of comprehensive centers, because we strongly
 3 believe, especially those of us that are ACEP
 4 members, that a lot of the data on thrombolytics
 5 is really -- it's the therapeutic -- the
 6 benefit/risk ratios are a lot smaller than some
 7 would have you believe. But we seen -- we seen,
 8 and we are starting to see some outcome data from
 9 our trauma centers. That's one of the indicators
 10 we added to the AHA guidelines, which weren't
 11 there. We put them in. We're starting to see
 12 some benefit. We're seeing less going to nursing
 13 homes, but we need to really get the data from the
 14 non-stroke centers, as well, and we haven't been
 15 able to get all those yet. But from what we've
 16 seen we've seen a slight improvement on those
 17 going to skilled facilities at our stroke centers,
 18 so if we can get that data and take a look at the
 19 other forty-three percent that are going
 20 elsewhere, we're hoping to be able to show that
 21 the system does make a difference. And a lot of
 22 these endovascular studies, while they may not be
 23 FDA -- while they're FDA approved as far as
 24 techniques, but may not actually be approved for

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1 general use, we're hoping that by having a decent
 2 window, we'll start to see cases and we can maybe
 3 get some data together and stated and put
 4 something forward like we did on some of the
 5 cardiac stuff.

6 DR. GOODMAN: Please don't
 7 misunderstand. I'm not suggesting that we don't -
 8 you know - move forward with rapid evaluation and
 9 treatment of patients that have consistent or
 10 severe deficits. It's the patient who has no
 11 deficits or very, very mild symptoms that we're
 12 dropping everything to evaluate when we
 13 potentially have much sicker patients in the
 14 emergency department.

15 DR. YOUNG: I think we all probably
 16 view it the same way, and I think we view a TIA
 17 kind of like an unstable angina that's now
 18 currently chest pain free. You have to have a
 19 heightened index of suspicion. In fact, in recent
 20 data, that shows a lousy outcome after thirty
 21 days. So they are clearly a patient -- you're
 22 right. You don't want to drop something life
 23 threatening to deal with, but they are not someone
 24 that should be put aside in a corner and forgotten

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1 about either.
 2 DR. GOODMAN: I think really --
 3 perhaps the recommendation is there are benchmarks
 4 for those patients with mild -- with disease and
 5 severity of the disease be stratified and that the
 6 benchmark be applied severity against disease, not
 7 -- someone with mild disease doesn't need -- is
 8 not going to be a thrombolytic candidate or a
 9 patient who potentially would qualify for some
 10 interventional technique not be placed in the same
 11 box or category as someone who wouldn't meet that
 12 criteria.

13 DR. YOUNG: Agreed. And that's one
 14 of the considerations we've been talking about,
 15 staging based on the NH stroke scale, although as
 16 you will see from the conference room -- the slide
 17 set, there is some data to suggest even some of
 18 the lower ones really do have some bad outcomes.
 19 So this is evolving ground is what it is, but it's
 20 very exciting, actually. Yeah. Actually, the
 21 slide sets are going to be placed on the website
 22 for availability, perhaps even doing that as we
 23 speak.

24 DR. HENRY: You can share that with
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1 us. I'm sure people would --
 2 DR. YOUNG: I'd be happy to.
 3 DR. HENRY: Any other new business?
 4 Hearing none, our next meeting is September 2nd
 5 and we will entertain a motion to adjourn.
 6 SPEAKER: So moved.
 7 SPEAKER: Seconded.
 8 DR. HENRY: All in favor? Meeting
 9 adjourned.
 10 (Whereupon, the meeting adjourned at
 11 4:10 p.m.)

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 2 C E R T I F I C A T E
 3
 4 I, Nora B. Lamica, a Shorthand Reporter and
 5 Notary Public in and for the State of New York, do
 6 hereby certify that the foregoing record taken by
 7 me is a true and accurate transcript of the same,
 8 to the best of my ability and belief.
 9
 10
 11 _____
 12 Nora B. Lamica
 13
 14 DATE: June 24, 2009