

SEMAC, 9-2-2009

APPEARANCES:

- Robert Burhans
- Lee Burns
- Sharon Chimento
- Craig Cooley, M.D.
- Arthur Cooper, M.D.
- Jeremy T. Cushman, M.D.
- Michael Dailey, M.D.
- Robert Delagi
- Phyllis Ellis, R.N.
- John Hassett
- Timothy Haydock, M.D.
- Mark Henry, M.D.
- Donna Johnson
- Bradley Kaufman, M.D.
- Joshua Kugler, M.D.
- Lewis Marshall, M.D.
- Israel Miranda
- Daniel Olsson, D.O.
- Michael Waters, M.D.
- Edward G. Wronski
- Gregory E. Young, M.D.

STATE OF NEW YORK
 STATE EMERGENCY MEDICAL ADVISORY COMMITTEE
 (SEMAC)
 Committee Meeting

DATE: September 2, 2009

TIME: 1:30 p.m. to 4:00 p.m.

LOCATION: Crowne Plaza
 State & Lodge Streets
 Albany, New York 12207

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(The meeting commenced at 1:30 p.m.)

DR. HENRY: I call the meeting to order, and the first topic that we're going to discuss before we go into our formal meeting, so we'll be off the record for this.

(Off-the-record discussion)

MS. JOHNSON: Dr. Broderick?

Dr. Cooley?

DR. COOLEY: Here.

MS. JOHNSON: Dr. Cooper?

Dr. Dailey?

DR. DAILEY: Here.

MS. JOHNSON: Dr. Davidoff?

Dr. Roland (phonetic spelling)?

Dr. DeTraglia?

Dr. Fairbanks?

Dr. Goodman?

Dr. Haydock?

DR. HAYDOCK: Here.

MS. JOHNSON: Dr. Henry?

DR. HENRY: Here.

MS. JOHNSON: Dr. Huffner?

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Dr. Kaufman?

DR. KAUFMAN: Here.

MS. JOHNSON: Dr. Kugler?

DR. KUGLER: Here.

MS. JOHNSON: Dr. Leinhart?

Dr. Marshall?

DR. MARSHALL: Here.

MS. JOHNSON: Dr. Martin?

Dr. Olsson?

DR. OLSSON: Here.

MS. JOHNSON: Dr. Takats?

Nonvoting members?

Sharon Chimento?

MS. CHIMENTO: Here.

MS. JOHNSON: Michael Mastriani?

Phyllis Ellis?

MS. ELLIS: Here.

MS. JOHNSON: Don Faeth?

John Hassett?

Robert Delagi?

Israel Miranda?

MR. MIRANDA: Here.

MS. JOHNSON: Mark Zeek?

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 2 Roll call complete.
 3 DR. HENRY: Okay. I want to note
 4 that Dr. Goodman called me this morning. He was --
 5 had to go back to his hospital because they had an
 6 emergency visit from the joint commission -- or a
 7 visit -- unannounced visit, let's put it that way.
 8 So, he -- he had -- he -- he went
 9 back, he was on his way. And Dr. Cooper called in
 10 earlier, too. And I saw Dr. Davidoff this morning
 11 but I don't know what happened to him at this
 12 moment.

13 FROM THE FLOOR: A question for
 14 order. Do we have a quorum?
 15 MS. JOHNSON: No.
 16 DR. HENRY: Okay. We don't have
 17 a quorum. Not at the moment. I want to -- we have
 18 a member waiting an appointment. Would you
 19 introduce yourself because you didn't get called.

20 DR. WATERS: Michael Waters,
 21 emergency director, Chenango Memorial in Chenango
 22 County and at regional REMAC.

23 DR. HENRY: Welcome.
 24 So, we want you to join in. All

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 2 right.
 3 MS. JOHNSON: We -- we also have
 4 another member waiting appointment. Dr. Jeremy
 5 Cushman.
 6 DR. HENRY: Oh, you're still
 7 waiting. Oh, I'm sorry. I didn't --.
 8 DR. CUSHMAN: Yes, I am.
 9 DR. HENRY: I thought they
 10 post --.

11 DR. CUSHMAN: Jeremy Cushman,
 12 Monroe/Livingston Regional E.M.S. director.

13 DR. HENRY: Okay. Because we had
 14 talked earlier, and I thought that he was seated
 15 because your predecessor, I said, "you still have
 16 to come to the meetings even though he has to
 17 travel to Buffalo for his K.O.A. grant, that's not
 18 an excuse." But we're glad to have you here, too.

19 Okay. So, we have a guest,
 20 Robert Burhans is here with us, and he's with the
 21 state disaster preparedness, and I'm glad you're
 22 here with us, because we are going to have some
 23 discussion on that. I understand you have an hour
 24 window.

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 2 MR. BURHANS: I do. I have a
 3 meeting to attend.
 4 DR. HENRY: Okay. Are you going
 5 to make a presentation, or --?
 6 MR. BURHANS: I have a few things
 7 I'd like to say and --
 8 DR. HENRY: Great.
 9 MR. BURHANS: -- I have a couple
 10 documents to -- to hand out.

11 Do I need to stay at the podium
 12 or can everybody hear -- hear me from here?

13 (Off-the-record discussion)

14 MR. BURHANS: Well, while they
 15 are trying to get the slides set up, my name is Bob
 16 Burhans. I'm the director of health emergency
 17 preparedness for the New York State Department of
 18 Health, and we, in the Department of Health have
 19 had a very busy summer, and I'm sure many of you
 20 folks have as well.

21 (Off-the-record discussion)

22 MR. BURHANS: Well, I think I'll
 23 start without the slides, and if I have to we can
 24 get -- we can get caught up.

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 2 The -- we all experienced with
 3 what happened in the spring with H1N1, and -- and
 4 we believe this fall we will have a resurgence, a
 5 second wave if you will, of the H1 -- novel H1N1
 6 influenza virus coming back to New York State, and
 7 we expect to see hopefully the same type of
 8 disease, the same severity of the disease that we
 9 saw in the spring, but we think we -- we may see
 10 more cases than we saw in -- in the spring. So, a
 11 few things to -- to note.

12 We began our -- our process of
 13 getting organized almost as -- as quickly as we
 14 shut down our incident management system in -- in
 15 the middle of response, and began to put together
 16 planning groups to be able to respond to the fall.

17 There are currently eleven
 18 planning groups, and -- and I'll go through them
 19 with you in a minute to give you an idea of -- of
 20 the kind of guidance that you'll be seeing coming
 21 out from the State Health Department very soon, and
 22 also to -- to talk a little bit about how we're
 23 structuring our -- our -- our planning going
 24 forward.

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 2 Suffice it to say that I handed
 3 out two documents. One is a strategic overview and
 4 the other one is a -- is a planning assumptions
 5 document, and what -- I'll get to both of them in a
 6 minute. I think the strategic overview document
 7 speaks for itself, so I'm not going to spend a
 8 great deal of time reviewing it. There are four
 9 pillars of our response, the four key areas that
 10 we're working on; one is surveillance and
 11 laboratory, and I think you all understand the
 12 importance of that.

13 Since this is a novel virus we
 14 have to be very careful that we watch it is it
 15 evolves. All flu viruses evolve, they change,
 16 they -- they -- they drift, if you will, and it's
 17 important that we -- we have a system in place to
 18 be able to monitor the virus. Particularly the
 19 severity of the disease.

20 And we're setting up a series of
 21 sentinel hospitals across the state. New York City
 22 is setting up five hospitals, and we are going to
 23 set up somewhere between six to eleven hospitals to
 24 specifically monitor the severity of the disease,

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 2 and get all the cofactors we need to be able to
 3 respond.

4 There we go. So, click off a
 5 few.

6 Okay. Next one.

7 Next one.

8 Okay. I'm going to go through
 9 these kind of quickly.

10 So, there's obviously a
 11 vaccination work group. In the spring we didn't
 12 have a vaccine, we wished we had one, for a lot of
 13 different reasons and we did not. We will have one
 14 this fall. And I'll -- I'll tell you that part of
 15 the challenge is when we're going to have it this
 16 fall, and when the disease is going to come back.
 17 And I don't think we'll know when that's going --
 18 going to be. Although, I'll tell you I was looking
 19 at the C.D.C. map of -- of occurrence and Georgia,
 20 whose schools go back the middle of August, they're
 21 already up to widespread. So, they're about a
 22 month ahead of us. Three -- three to four weeks
 23 ahead of us in time.

24 Thier schools went back, and

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 2 because this is a disease that disproportionately
 3 effects the young, and those are the people who are
 4 most susceptible to disease from an antigenic
 5 response, it's -- it's already starting to -- the
 6 cases are -- case increases in -- in -- down south,
 7 and if we look at what happened in the southern
 8 hemisphere, I think we're going to see the same
 9 thing happen here after our schools go back into
 10 session.

11 So, this group is working on all
 12 the issues you can associate with a vaccine. It's
 13 important that everyone understand that seasonal
 14 flu vaccine is out there, and it's still important,
 15 and it should be -- it should be as -- used as --
 16 as broadly and as widely as possible. If -- if we
 17 have both of these diseaseing -- diseases occurring
 18 simultaneously that will have huge impacts on our
 19 hospital system.

20 Most of you know that during
 21 regular flu season, our -- our hospitals -- many of
 22 them are at capacity dealing with just seasonal
 23 flu. And I say just seasonal flu, but seasonal flu
 24 is still a serious disease, it causes a lot of

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 2 death and hospitalizations in this state. And H1N1
 3 we think it will return about the same severity,
 4 but these diseases if they were to queue up in the
 5 same time frame would -- would strain our -- our
 6 system. So, vaccination is going to be important.

7 Next.

8 I talked about surveillance, and
 9 the fact that we need to -- we need to check this
 10 disease and watch it carefully because it can
 11 change, and severity of the illness is of
 12 particular concern to us.

13 And I'm going to go through these
 14 quickly. Next.

15 Healthcare surge and triage:
 16 While what occurred in the spring, particularly in
 17 New York City, was mostly an E.D. and outpatient
 18 phenomena, I think we still need to be aware that
 19 this could -- could increase the number of
 20 inpatients as -- and particularly when it comes to
 21 pediatric inpatients. That could be a challenge to
 22 us, we don't have a lot of pediatric capacity to
 23 begin with, and that could potentially easily be
 24 exceeded. So, we're working -- we have a team

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2 that's working to look at issues for hospital
3 emergency departments and ways to divert people
4 away that don't need to be there.

5 Most of the people that went to
6 the E.D.s, particularly in New York City, were not
7 seriously ill. They had mild illness, and they
8 were there for a whole series of bad reasons. They
9 were trying to get tested, which they weren't
10 really going to get tested if they went to the
11 hospitals. Some of them were trying to just make
12 sure that their kids, who had a sibling in a school
13 that was -- that -- that was closed, that their
14 children were safe, and so there was a lot of
15 people going to the E.D. unnecessarily. We need to
16 work diligently to make sure that doesn't happen
17 again this fall, but we also need to make sure that
18 if we have to inpatient surge, we have a place to
19 do that.

20 Next.

21 Healthcare infection control: We
22 need to continue to provide ongoing guidance to the
23 facilities on infection control. One of the things
24 we learned this spring, and I'm -- I'm -- I'm

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2 speaking to the people that probably know this
3 better than I do, is that we identified two
4 groups -- long-term care providers and E.M.S. that
5 were not necessarily fully in compliance with what
6 we would consider good respiratory protection,
7 particularly around the respiratory protection
8 standard in OSHA and others, and we know we need to
9 improve that to protect these vital workers to make
10 sure we keep our healthcare system alive.

11 And it's also important, I think
12 most of you know this around the table, but I mean
13 if a hospital has to surge, the first thing they
14 attempt to do is discharge some of their patients
15 to others -- other alternate -- other -- other care
16 facilities in order to create inpatient surge. So,
17 essentially our -- our long-term-care facilities
18 really need to be up to speed with all the
19 infection control standards that a hospital
20 might -- might have.

21 And we found our hospitals were
22 in very good shape, and were by and large, in
23 compliance. So, we need to make sure that the
24 continuum of care everywhere from E.M.S., long-term

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2 care, as well as the hospitals, are all up to speed
3 on -- on -- on good infection control practices.

4 Community mitigation: In the --
5 in -- in the spring, community mitigation meant
6 school closures, which was -- was an interesting
7 experience. School closure requirements or
8 recommendations from C.D.C. changed almost every
9 other day.

10 Given the fact we had the whole
11 summer to work on it, and take a look at the
12 disease, I think we now have some good -- good
13 guidance in place. The governor and the
14 commissioner went -- started in Albany on Monday,
15 and have gone across the upstate New York, and the
16 mayor and the -- and -- and the city health
17 commissioner, on September 1st, had a series of
18 briefings basically putting out guidance that says
19 that our goal is to keep the schools open, but our
20 goal is also to keep kids who are sick home, and
21 not going to school, to infect their -- their --
22 their classmates.

23 And so, I -- I think we have got
24 really good plans in place. A lot of the effort

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2 with this this -- this summer went into working
3 with State Ed in getting some good guidance out
4 there.

5 One of the things that we do need
6 to -- that this group is also looking at, is
7 putting out specific guidance should the disease
8 become more severe.

9 Unfortunately, most of the
10 community mitigation measures work well with a
11 severe disease when you implement them early,
12 before the disease begins to spread, and that is
13 one of the problems we're going to have if the
14 disease changes midstream. So, the disease is
15 already circulating in the community, it then
16 becomes more severe, we're not sure that all the
17 community mitigation strategies will work at that
18 point, because of the fact that the disease is
19 already spreading in the community. So, that's one
20 of our challenges.

21 Legal issues: Our house counsel,
22 Barb Asheld leads a Department-wide work group
23 looking at a number of issues. There are prep act
24 declarations, and -- and -- and other declarations,

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 2 which deal with liability and immunity for the
 3 vaccine and the other medical countermeasures, and
 4 we want to make sure that our division of legal
 5 affairs is up to speed on all those and sharing
 6 information with hospital executives, but also
 7 county attorneys and others so that there's a full
 8 understanding of what's out there to protect the
 9 healthcare system in -- in -- in this -- in this
 10 response.

11 Clinical management: Before we
 12 end up with a vaccine, we're going to have
 13 antivirals as being our -- our -- our major way to
 14 deal with people who are at-risk for negative
 15 outcomes, and to be able to prophylax and treat
 16 them. So, we need to make sure that we get very
 17 good guidance out there on what's the appropriate
 18 use of antivirals.

19 I'll tell you we track Medicaid
 20 prescriptions, and we have been tracking them for
 21 Tamiflu and Relenza, and it's just interesting to
 22 note in the New York City area, there are still
 23 three standard deviations above what is normally
 24 seen this time of year. So, even though there's no

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 2 rampant H1N1 circulating out there. People are
 3 getting their prescriptions. They're buying it,
 4 and -- and either using it prophylactically or
 5 beginning to stockpile it for the fall. So,
 6 that -- that -- that continues to be out there and
 7 we're watching it.

8 The good news is supply
 9 chain-wise, it's widely available out there, and
 10 that's -- that's the good news. We're not having
 11 any shortages in the supply chain.

12 Public information and risk
 13 communication: Again, this is an overarching group
 14 that is working on putting together public
 15 messaging for all the issues. But you'll see one
 16 of the first things that they're going to do is a
 17 campaign to really address hospital E.D.
 18 overutilization. That's got to be a message that
 19 we get out every single day.

20 It has to be a message that all
 21 the providers also give. We can't have doctors
 22 telling their -- their -- their clients and
 23 patients to go in to the emergency department in
 24 order to get a test, or in order to get antiviral

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 2 medication. So, we need to work through the
 3 providers, but also with the public to get the
 4 information out. And this group is about ready to
 5 release a whole bunch of risk communication/public
 6 information messages over the next couple weeks.

7 Education: This is a group that
 8 is trying to coordinate all of the partners we have
 9 in this effort and trying to make sure that we have
 10 a way to communicate effectively with them now, but
 11 also as we go forward. So, some of you may have
 12 heard about a series of healthcare forums that are
 13 occurring across the state. There was one in
 14 Westchester that occurred on Monday, and there is
 15 one tomorrow in Long Island, bringing in hospitals,
 16 long-term care providers, community health centers
 17 and others, local health departments, in -- into
 18 meetings to begin to give them the message and give
 19 them some guidance as to what they need to do to
 20 prepare for the fall.

21 Okay. Occupational health and
 22 safety work group is focusing on the other
 23 infection control issues outside of the healthcare
 24 facilities. So, what is our guidance on basic

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 2 use -- mask use for those people who are not
 3 healthcare providers; and what do we need to do to
 4 make sure that they've got the best information?
 5 And we're working with the corrections officers and
 6 others on getting the right information out to
 7 them, so they're -- that they understand what they
 8 should be doing to protect themselves.

9 And then lastly, data: It's nice
 10 to have all these surveillance systems, and it's
 11 nice to be able to -- to look at them, but you
 12 really need to have this data available day to day,
 13 so decisionmakers can look at the data and make
 14 decisions. We know -- you know, our syndromic
 15 surveillance system in New York City and New York
 16 State was the best system we had for tracking
 17 E.D. -- E.D. overutilization. We tracked I.L.I.
 18 illness, and we were able to look at that on a
 19 day-to-day basis, and it was the most reliable data
 20 we had, so we used the disease surveillance system,
 21 but we used it to actually look at E.D.
 22 utilization, and it was very effective.

23 The problem is, is that the
 24 people who had access to that data were the

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 2 epidemiologists not the people in the office of
 3 health systems management, which really needed it.
 4 So, part of what we're doing is
 5 we're working to make sure this data is available
 6 in a dashboard, so everyone in the Department who
 7 needs to make -- have access to information for
 8 decisions will have equal access to it. And also
 9 that dashboard will be available to clinicians, and
 10 to, we hope, all the hospitals in the state, so
 11 they can have a view of what's going on in their
 12 region. And that's something we're working on
 13 right now.

14 Okay. That was my life. That --
 15 this list here, and a group of people within the
 16 Department. On April 15th and 17th, we listened
 17 with interest to C.D.C. tell us that they had
 18 identified two novel H1N1 cases in Texas and
 19 California, and I remember sitting at a table with
 20 a group of our epidemiologists and we were on a
 21 phone call with epidemiologists from New York City,
 22 and I said, "well if it's in Texas and California,
 23 it's got to be in New York City," and sure enough,
 24 April 24th we were notified that there were

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 2 probable cases in New York City associated with a
 3 school in Queens.

4 That day we implemented our
 5 incident management system, and that incident
 6 management system stayed up managing the disease
 7 event through June 25th.

8 On June 25th, we shut down, but
 9 not really shut down. We shut down our incident
 10 operations management and went into a planning
 11 mode. On July 2nd, those work groups that I
 12 described to you were put together. On the 28th of
 13 July we had a state agency briefing for the
 14 Disaster Preparedness Commission, briefing all the
 15 state agencies because most of what -- how are you
 16 doing, Art?

17 Most of what we're doing requires
 18 the help of other folks. When we push out masks
 19 and Tamiflu and other things, obviously that's not
 20 the State Health Department that's doing that.
 21 That's the Corrections Department, Office of
 22 General Services and the Division of Military and
 23 Naval Affairs. So, we need to make sure our
 24 partners are with us, and know what we're doing,

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 2 and are ready to support us for the fall.
 3 On the 30th we had a meeting with
 4 New York City Department of Health and Mental
 5 Hygiene and the State Health Department to make
 6 sure that we were aligned, so that whatever we were
 7 doing and whatever they were doing, we were giving
 8 a single message, and we -- that was a very
 9 successful day-long meeting and we've had a series
 10 of follow up calls making sure as we progress,
 11 we're giving the same information out, and where
 12 the information is different -- which there is some
 13 information that's going to be different,
 14 particularly around the logistics associated with
 15 gaining the vaccine, we both know how we're doing
 16 it, so that we can provide that information to
 17 people if they call us, so that they -- we're not
 18 sending them around a circuitous route to get
 19 information.

20 If we have information, we'll
 21 provide it, and New York City Department of Health
 22 and Mental Hygiene will do the same for us.

23 On the 7th the commissioner of
 24 health convened a commissioner's call -- that's

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 2 kind of like a mandatory show. Every state --
 3 every county health officer in the state has to
 4 come to that meeting. It's required in the Public
 5 Health Law. That meeting was on the 7th, which was
 6 a good meeting to get feedback from the local
 7 health department on some of our draft plans to
 8 make sure that they were aware of what roles we
 9 were asking them to play, and they were prepared to
 10 play those roles, and then beginning in August, and
 11 now going through September, we have a series of
 12 regional health facility meetings.

13 So, that's -- you know, I think
 14 that's -- we -- we have more to do believe me, but
 15 we're getting out there, and we're trying to get it
 16 done to be ready for the fall.

17 Planning in a high degree of
 18 uncertainty: I mean the good thing is I have a
 19 bunch of docs here that are emergency department
 20 physicians who see uncertainty every day, and I've
 21 got E.M.S. people that do the same. So, this is
 22 not going to be a revelation to -- to -- to -- to
 23 you folks, but to others out there who are
 24 particularly are scientists that like all the

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2 answers before they develop a policy, and you all
3 know that that doesn't work when you're trying to
4 plan for an emergency.

5 So, we needed to initiate and
6 complete our process prior to September 15th, and
7 we could probably push that back a little bit if
8 the -- if the disease is -- is slow to come back,
9 but that's about three incubation periods after
10 school goes back in, so I think that's probably a
11 reasonable time to believe that we're going to
12 start seeing an increased number of H1N1 cases
13 appearing.

14 I'd like to be proven wrong, but
15 I -- it would be nice not to have any cases
16 reappear until October 15th when we have vaccine,
17 but I don't think that's a likely scenario.

18 There's a tremendous degree of
19 uncertainty, and some of that uncertainty is about
20 the disease, and some of that uncertainty comes
21 from the federal government in dealing with the
22 vaccine, particularly about when it's going to be
23 available, how much is going to be available, how
24 they're going to make it available to us, and --

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2 and all of those considerations cause us to have
3 incomplete plans, and not be able to share with
4 anyone else the plans that we would like to give
5 all of you.

6 With that said, what we've done
7 is created a series of planning assumptions, and
8 I've given you a copy of those as well, and these
9 are on the H.P.N., and they change almost every
10 Friday, unless there's nothing to update them
11 against, in which case they may -- we may leave
12 them in place for another week, I don't make small
13 changes. We try to make just the -- the large
14 important ones.

15 If -- they're date stamped, and
16 they will change as the information that we get
17 improves. The more information is known, the more
18 the assumptions will be turned into planning
19 requirements, and they'll be date identified, and
20 we'll continue to post them on the H.P.N. and the
21 H.I.N.

22 So, that's how we're going to
23 manage the fact that we don't have all the answers
24 we need to put our plans in place. We're -- we're

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2 using this with our local health departments, in
3 these series of road shows. We're going around the
4 state with hospitals and our other -- our other
5 partners are providing the same information to
6 them, so incrementally they can all stay on the
7 same page with us as we move forward.

8 Some of the largest issues right
9 now that we're facing, are how many direct-ship-to
10 sites we're going to have in the state. C.D.C.
11 has -- has -- has told there's ninety thousand for
12 the nation, but they haven't given New York State a
13 number. But just to give you an idea, if we got --
14 if we got three thousand, we have over twenty-four
15 hundred vaccine-for-children providers alone in the
16 state, so three thousand is not going to be enough
17 to be able to have C.D.C. direct ship the vaccine
18 to those endpoints. That means that we're going to
19 have to take that on at the State Health Department
20 for whatever that -- that delta is. So, that's --
21 that's one issue.

22 I -- I can tell you from -- we
23 believe hospitals will definitely be a
24 direct-ship-to site. So, for those of you

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2 affiliated with a hospital, you will be identified
3 as a direct-ship-to site, and the vaccine will --
4 and -- and the affiliated materials, needles, gauze
5 pads, sharps containers, will be sent to you in the
6 same quantity of the vaccine that is sent to you as
7 well.

8 Again, the federal government, if
9 you're a direct-ship-to site, I'm not going to
10 guarantee you're going to get both of those at the
11 same time, because that -- that would just be a bad
12 guarantee for me to give you.

13 If we ship them out from the
14 State Health Department, you'll get them at -- at
15 the same time. I'm not going to make that same
16 guarantee for the -- for the federal ship-to sites.

17 So, that's where we are in --
18 in -- in the planning effort. I wanted to give you
19 that update. And now, I do have some time for
20 questions, so let's -- let's open it up.

21 MR. WRONSKI: Bob and I talked
22 just before the presentation, and -- and he can
23 clarify the regulation regarding mandated
24 vaccinations.

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 2 MR. BURNHAM: Yeah. Let's --
 3 let's talk about healthcare worker vaccination.
 4 There's some confusion out there,
 5 and so let's talk about I think what's causing some
 6 of the confusion. The A.C.I.P. set priority groups
 7 up, and remarkably, and we were very happy with
 8 this, healthcare workers were like the number one
 9 priority group for receiving vaccine. You know,
 10 pregnant women are right up there, but healthcare
 11 workers are in that -- that first group.

12 That's good information, because
 13 we advocated, in the old pandemic plan -- remember
 14 that plan we had on the shelf? Healthcare workers
 15 weren't on the top tier. Police and fire were, but
 16 the healthcare workers weren't.

17 We thought that was a bad
 18 decision. We advocated, and it looks like we were
 19 successful in getting that changed. That's the
 20 good news. So, you are on the top of the list
 21 collectively for receipt of the H1N1 vaccine.

22 Simultaneously, or independently
 23 of H1N1 being an issue, the Department of Health,
 24 based upon ten years of information that healthcare

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 2 workers weren't availing themselves of vaccine, and
 3 we were having a series of nosocomial outbreaks in
 4 long-term care facilities as well as hospitals,
 5 influenza outbreaks with negative consequences for
 6 patients, the Department decided -- by the way,
 7 the -- the immunization level was about forty
 8 percent. Even after sending tool kits out. Even
 9 after you know doing information campaigns to -- to
 10 improve that number, healthcare worker vaccination
 11 in the state was about forty percent.

12 The department decided to
 13 promulgate a regulation requiring healthcare
 14 workers to be vaccinated with seasonal influenza.
 15 And that was begun long before we even knew H1N1
 16 was actually out there, that process.

17 So, that's just background
 18 information. Some people think that it was done
 19 specifically to require H1N1 vaccine. It was not.
 20 It was done to deal with a longstanding issue in --
 21 in the healthcare facilities. So, the regulation
 22 was passed and says that Article 28 facilities are
 23 required to vaccinate their employees, and it is a
 24 condition of employment.

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 2 Just like M.M.W.R. vaccine is,
 3 and -- and the other -- and the other tests for
 4 T.B. and other things. It's just a condition of
 5 employment in order to be employed. In the direct
 6 patient contact you have to meet those
 7 requirements.

8 And it was passed unanimously by
 9 SHRPC and filed as an emergency regulation so it
 10 could be effective for the upcoming influenza
 11 season.

12 The question is, is whether
 13 E.M.T.s are a part of -- of -- you know, are a part
 14 of the required, they're -- they're all in the
 15 priority groups. So, you are in the priority
 16 group, so from that standpoint vaccine will be made
 17 available to E.M.S. The question is, is if you
 18 read the regulations, there's a section in there
 19 that says that people who -- who have direct
 20 patient contact that are affiliated with a hospital
 21 need to be able to be vaccinated as well.

22 Right now -- and we're waiting --
 23 we are waiting for the formal counsel. It looks
 24 like if you are employed by an Article 28, it would

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 2 be automatic that you'll need it, but right now it
 3 looks like if you're not, if you're just going to
 4 be coming to the hospital, you may not -- and
 5 you're not an employee of the hospital, it will be
 6 strongly recommended, but that is still making its
 7 way through the division of legal affairs, and when
 8 that's done, is final, we'll get it out to all of
 9 you.

10 So, that's -- that's where it is
 11 at -- at this moment.

12 Any other -- any other questions?

13 Yes, Art.

14 DR. COOPER: Bob, the reg
 15 addresses the seasonal flu vaccine --

16 MR. BURNHAM: Correct.

17 DR. COOPER: -- as I recall, the
 18 specific wording of it, because that's, as you
 19 indicated the way it was proposed, will that be
 20 deemed to imply that healthcare workers must
 21 receive both the seasonal vaccine and the H1N1
 22 vaccine, when it becomes available?

23 MR. BURNHAM: Yes. Both.

24 DR. COOPER: Okay.

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 2 MR. BURHANS: The only -- the
 3 only caveat, I would put to that is that the date
 4 of -- for compliance is November 30th, and if there
 5 is an availability issue for the H1N1 vaccine,
 6 that -- that date -- that window may be moved back.

7 But right now, with the
 8 information that we have, and again this is subject
 9 to change, we believe around October 15th, we'll
 10 receive a bolus of forty-five million doses,
 11 followed up by twenty million doses a week
 12 nationally. That's not what New York -- we'll get
 13 our percentage of that, and if that happens, we
 14 believe we'll have enough vaccine to address all of
 15 the priority groups that A.C.I.P. has outlined in
 16 about eight weeks. So, just from playing the
 17 numbers, it looks like eight weeks to get to
 18 that -- to that location.

19 DR. HENRY: Just going back to
 20 your prior comments on waiting for interpretation
 21 of whether E.M.T.s will be required to have the
 22 vaccination, is it the intent of the planners that
 23 that be the case, and you're just waiting for
 24 interpretation prior to going through another

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 2 channel, or -- I mean what is the -- what is the
 3 intent of the group?

4 MR. BURHANS: I think the intent
 5 of the regulation was any -- anybody that had
 6 patient contact should be vaccinated.

7 DR. HENRY: Okay.

8 MR. BURHANS: So, that's the
 9 intent of the regulation. The question is whether
 10 or not legally we can require E.M.T.s, who are not
 11 employees of Article 28, to get it. And -- and
 12 that's a question I can't answer.

13 DR. HENRY: Well, I would just
 14 say for information, that in many areas, patients
 15 transported by ambulance, whether they're volunteer
 16 ambulances or Article 28 ambulances, the admission
 17 rate is over forty percent --

18 MR. BURHANS: Right.

19 DR. HENRY: -- and many of those
 20 people have comorbid conditions, and are going to
 21 go upstairs in the hospital, so if we're looking at
 22 nosocomial prevention --

23 MR. BURHANS: I -- I --

24 DR. HENRY: -- that's a very

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 2 important population.

3 MR. BURHANS: -- I -- we don't --
 4 we don't disagree with you. But you know, it may
 5 be the difference between required versus strongly
 6 recommended. And that -- and that we'll have to
 7 see.

8 Bob?

9 MR. DELAGI: Hi, Bob. I
 10 understand the discussion in the context of E.M.T.s
 11 as -- as you just related.

12 Can you comment on the piece of
 13 the regulation that requires students who go into
 14 hospitals? Our reading of the regulation makes it
 15 crystal clear that the students we send to
 16 hospitals for clinical time would be required to
 17 have this added to the list of already required
 18 immunizations in the 405 Regs.

19 MR. BURHANS: That's my
 20 understanding.

21 MR. DELAGI: Thank you.

22 MR. BURHANS: Yes?

23 DR. DAILEY: Bob, Mike Dailey
 24 from this Albany area. One of the things we

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 2 discussed this morning prior to you getting
 3 here --.

4 DR. HENRY: Can you use the mic,
 5 the microphone?

6 DR. DAILEY: Sorry about that.

7 We discussed something this
 8 morning that I just wanted to get your input on.
 9 There were two pieces to your planning assumption
 10 of emergency services personnel being responsible
 11 at an occupational setting for getting -- getting
 12 vaccinated there.

13 The first thing, is that
 14 emergency services personnel in New York State, as
 15 certified not licensed providers, can't currently
 16 give vaccinations, and I'm hoping that's on your
 17 radar and part of what the process you're working
 18 on will address.

19 And the second is, using these
 20 people as part of the outreach into the community
 21 and whether or not that's also part of that
 22 planning process.

23 MR. BURHANS: Well, let me talk
 24 about the first one. Ed and I've had this

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 2 conversation. Where we are right now is the
 3 Department is assembling a list -- in collaboration
 4 with the New York City Department of Health and
 5 Mental Hygiene, a list of rules and regulations
 6 that are going to be a barrier to a successful fall
 7 response to the H1N1 virus.

8 And then, once we -- we compile
 9 those, we'll be presenting those through our
 10 counsel's office and through the State Emergency
 11 Management Office to the governor for a potential
 12 Article 2(b) declaration to -- to waive certain
 13 requirements in law to be able to make this effort
 14 this fall actually happen.

15 And in -- in that will also be
 16 issues around medical surge. The hospitals have
 17 made us aware of a series of requirements in state
 18 law that would be beneficial to waive as well, to
 19 make medical surge more easily accomplished during
 20 the -- during the fall.

21 And so, we've compiled those.
 22 I'm certainly not going to speak for the governor,
 23 but it is part -- it is part of our considerations.

24 DR. DAILEY: Thank you.

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2 MR. BURHANS: Yes.

3 MS. ELLIS: Hi, Bob. I have one
 4 question, one clarification, from the hospital
 5 side. Dr. Cooper's question about the mandatory
 6 immunizations for the seasonal flu, we got that
 7 mandate. Did you say that the H1N1 will be
 8 mandatory for all healthcare workers?

9 MR. BURHANS: Yes.

10 MS. ELLIS: It will be? Okay.

11 And secondly, and the seasonal
 12 flu, have you guys yet identified the fact that the
 13 availability of the flu vaccine is not there
 14 currently, over and above what we previously
 15 ordered last year anticipating, and the price
 16 gouging has already started?

17 MR. BURHANS: Yeah. I'm -- a
 18 couple things on seasonal flu vaccines. So, let
 19 me -- let me -- because it is an issue, and you
 20 know, the -- the -- the people in our immunization
 21 bureau that deal with vaccinate -- vaccine every
 22 year, they're not too surprised by what's going on.
 23 But let me just tell you what we -- we believe is
 24 going on, and what -- what we hope will happen.

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 2 First of all, this year there's
 3 going to be about a hundred and twenty-five million
 4 doses of seasonal flu vaccine produced. That's
 5 anywhere between fifteen to twenty million doses
 6 more than has ever been produced, and even every
 7 year what's produced, I can tell you every June
 8 30th when it used to expire, tens of thousands of
 9 doses were thrown out in addition to what was
 10 produced. So, there's -- there's -- we got
 11 twenty-five million more -- up to twenty-five
 12 million more doses than we've ever produce before,
 13 and -- and so we don't think there's going to be a
 14 shortage, but what we know happens -- and this
 15 comes, you know, because our immunization folks
 16 deal with these providers all the time is, everyone
 17 will -- there are like five distributors.

18 Because of the issues of -- of --
 19 of supply, and when you get your supply, what often
 20 happens is people triple book. They go to three
 21 distributors, and they order five thousand doses.
 22 They only need five thousand doses, but they order
 23 five thousand doses from three distributors.

24 And then what happens is the

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2 first distributor that fills that order, then they
 3 call up and cancel their other orders, because they
 4 don't need them now, because they've gotten
 5 their -- you know, in other words, they're --
 6 they're playing more bets than what they need to
 7 accomplish their end gain. And what happens is as
 8 those other orders are cancelled, as -- once the
 9 system starts to produce vaccine and it gets
 10 shipped, you'll see those other orders cancelled,
 11 and there will be availability.

12 So, you really need to work with
 13 your distributors to let them know as that
 14 availability opens up, they need to get back to
 15 you.

16 MS. ELLIS: Just --.

17 MR. BURHANS: I can't fix the
 18 problem. I'm just telling you --

19 MS. ELLIS: Yeah.

20 MR. BURHANS: -- that's what the
 21 problem is.

22 MS. ELLIS: No, I understand the
 23 answer, and obviously we were able to do that
 24 through another distributor, but then the cost went

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 2 extremely higher than it was previous to our order
 3 last year. The -- the --
 4 MR. BURHANS: We'll -- we'll --
 5 MS. ELLIS: -- stuff that we just
 6 ordered for this year.
 7 MR. BURHANS: -- we'll -- we'll
 8 pass that on to the bureau of pharmacy, Larry
 9 Mochaimer's (phonetic spelling) group. I mean,
 10 we -- we don't regulate the distributors, but they
 11 do, and if there's some gouging going on, they
 12 ought to be aware of it.
 13 Let me go back to Mark.
 14 DR. HENRY: A couple comments
 15 from our meeting last June, as well as earlier
 16 today, which had to do with dispatch centers. And
 17 the first is, is there an alternate number for
 18 people to call when they're seeking information,
 19 besides nine one one, as to what to do with their
 20 condition? And there was variation in response
 21 around the state. And so, if you could address
 22 that first.
 23 MR. BURHANS: Well, I think there
 24 is variation around the state. I know New York

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 2 City is trying to do something. They're putting
 3 out an R.F.P. to go with a contract center with
 4 nurses, and we're aware of that effort, and
 5 actually we're working with them with State Ed,
 6 which again I'm not going to make any promises, but
 7 there's -- there's issues that we need to work
 8 with, with the State Ed to make this happen.
 9 We know that there are three one
 10 one centers that are doing this, and we have an
 11 eight hundred number as well, the State Health
 12 Department has published a call center number as
 13 well. And we're putting information on -- one of
 14 the public information things that was mentioned
 15 from that communications group is a checklist that
 16 people can go down and -- and answer questions of
 17 whether they need to see their doctor, or they need
 18 to go and -- and seek medical care, so that they --
 19 we don't have lots of people going.
 20 So, we're producing a lot of
 21 public messaging around the issue. We're going to
 22 put a lot of information out on our Web site and
 23 get it out through other -- through other --
 24 through other messages, and we -- our call -- our

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 2 call script that we provide to the eight hundred
 3 number, we also provide to all the counties around
 4 the state, so they have -- they can use it for
 5 their three one one centers if they have them.
 6 So, we're trying to standardize
 7 the message as much as possible.
 8 DR. HENRY: Okay. And the second
 9 was -- and this came from our last meeting. Mr.
 10 Wronski said that the dispatch centers should have
 11 at least E.M.T. training, or emergency medical
 12 dispatch training, and they should work with their
 13 local REMACs in terms of what the response is to a
 14 call for help.
 15 So, I'm wondering if in this
 16 circumstance that your department could issue such
 17 directives, so that there's not an automatic
 18 response of an ambulance to a call to nine one one
 19 that results in an unnecessary transport to an
 20 emergency department for someone with
 21 influenza-like illness.
 22 Maybe Dr. Kaufman will speak on
 23 their experience on this, because it's another
 24 point that's before the E.R. that can overwhelm the

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 2 system.
 3 MR. BURHANS: We -- we are. And
 4 we -- we know what New York City's working on, and
 5 we support what they're doing. I'm not quite sure
 6 if all the other public safety answering points in
 7 the state have that same capability, or want to
 8 take that on as an -- as an issue. At least we
 9 haven't heard it with any uniformity, so -- but go
 10 ahead, Dr. Kaufman.
 11 DR. KAUFMAN: I think you're
 12 right that -- we -- it -- it's beneficial to have
 13 the ability to somehow take those people who call
 14 nine one one, but maybe aren't even looking to go
 15 to the hospital, or do not need to go to the
 16 hospital, but they don't maybe have an ambulance
 17 response, especially when you already have a
 18 stressed out E.M.S. system.
 19 Something we've learned, and
 20 that's where all these call centers come in. I
 21 think, one, it would be nice if the nine one one
 22 call could be transferred to the call center, and
 23 there's enough safety measures in place that you
 24 would be sure you're not missing anybody who really

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2 would benefit from an ambulance. And that's what
3 we working for in New York City.

4 I think what we're more and more
5 considering is that depending on how the epidemic
6 evolves, and if people need Tamiflu, there -- there
7 needs to be a mechanism to get people Tamiflu, so
8 even if they call a call center or the eight
9 hundred number, and they are assessed according to
10 the criteria and found to be high risk, or found to
11 be high risk enough that they need -- they would
12 benefit from prophylaxis or treatment, but do not
13 need to go to an emergency department, there needs
14 to be a mechanism put in place where that
15 prescription can be waiting for them at a local
16 pharmacy, or somehow referred to them; otherwise
17 I'm afraid we're going to be stuck in a loop of
18 transporting these patients to the emergency
19 department.

20 That's something we're looking
21 into now as well.

22 DR. HENRY: But that -- this
23 would be rather novel, and different than current
24 practice, but even if these calls were diverted to

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2 medical control, for example, influenza-like
3 illness, and a decision was made that it didn't
4 require transport to a place that was crowded with
5 people who didn't need to be exposed, that would be
6 in the public benefit. But it would take some
7 directive beyond us, because we have little
8 influence over dispatch in general in many parts of
9 the state.

10 DR. HENRY: Go ahead, Mike.

11 DR. DAILEY: Sorry. I was just
12 actually if I may, ask a question to -- to Brad.
13 You know, it's interesting that our point of
14 contact to the public would be through a
15 dispatcher, and to try to stop the mechanism of
16 nine one one response and transport there. Is New
17 York City working on a no-load plan, so the
18 ambulance does go and says, "actually, you're doing
19 okay. You stay home." And are you going to bring
20 that to us to take a look at, at some point?
21 Because that sounds fascinating.

22 DR. KAUFMAN: There's -- we have
23 a -- we've certainly been talking about that. None
24 of these have been decided for sure.

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2 DR. DAILEY: Right.
3 DR. KAUFMAN: But certainly,
4 again depending on what the scenario is, there may
5 be some advantages from having a crew on the scene
6 who could check vital signs, and get a few -- you
7 know, listen to lung sounds. Get a little bit more
8 of a history before making that decision. And
9 that's a -- that has its own issues involved
10 with -- of no load.

11 The idea of even -- if you want
12 to go further of, maybe saying, you know, they'll
13 be a van coming by in a couple hours to take you to
14 the community health center, because you fit into
15 those low-risk criteria. So, there's -- there's
16 certainly lots of options we've been discussing in
17 the city. I don't think we've finalized any of
18 them.

19 DR. HENRY: Well, we discussed
20 this, in part, at our last meeting because at that
21 point of contact, if someone is not critically ill
22 that they would require going to an emergency
23 department, but they fit the program as you talked
24 about, and they had high risk where they could

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2 qualify for prophylaxis, to distribute them such
3 care without -- with -- while keeping what we're
4 talking about as the current quarantine - which is
5 really self-imposed, stay in your own place,
6 correct, we're discouraging people from going
7 outside and mixing - and if we can prevent that
8 and -- that would be consistent with the other
9 plans.

10 DR. KAUFMAN: And I -- I'll --
11 I'll mention one more thing, which may be the most
12 controversial, is after the assessment allowing the
13 paramedics to give the Tamiflu. Certainly has a
14 lot of --.

15 DR. HENRY: Under medical control
16 or a standing order.

17 DR. KAUFMAN: Yeah. On both
18 sides. And that's probably much further away, but
19 it's certainly a good idea.

20 MR. BURHANS: Bob.

21 MR. DELAGI: Bob, just the --
22 the -- the comments that Dr. Henry is making are
23 already a reality for us, in that the National
24 Academies of Emergency Medical Dispatch has already

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 2 issued protocol --
 3 MR. BURHANS: Yes.
 4 MR. DELAGI: -- thirty-six for
 5 pandemic influenza. And that actually has a
 6 determinat code for us, where the E.M.S. system,
 7 or the PSAP, will not send an ambulance to patients
 8 with I.L.I. And that's a huge policy shift in --
 9 in the public's perception of nine one one, and
 10 it's a huge policy shift of a calltaker and a
 11 physician making a determination over the phone
 12 that the patient does not require a hospital.
 13 And I'm -- I'm wondering if
 14 there's any discussion, at your level, about what
 15 ambulance folks can or cannot do with regard to
 16 transporting to an alternate care facility off
 17 hospital campus. I think on hospital campus is the
 18 easy one. But off hospital campus, or this notion
 19 of E.M.S. providers and agencies selectively not
 20 sending an ambulance to a call for help. I -- I
 21 think those are some serious legal issues that --
 22 that we need some help with.
 23 MR. BURHANS: Those are issues
 24 that are -- that are -- that are under

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 2 consideration as part of that waiver that we talked
 3 about. But right now, on Wednesday, was the date
 4 for the --
 5 MR. DELAGI: Uh-huh.
 6 MR. BURHANS: -- all those work
 7 groups to dump their plans on me. And so, we have
 8 staff right now that are putting those plans into a
 9 coherent framework, and my job tomorrow and after
 10 going to the healthcare forum in Long Island, is to
 11 read those documents and make -- make recommended
 12 approvals or suggestions to our department's
 13 executive staff which are meeting on Friday.
 14 So, I think you'll be seeing the
 15 protocols -- I'm -- I'm -- you know, right now I've
 16 got to go back and read the -- read -- read what
 17 my -- my work groups -- there's eleven of them, and
 18 I -- I sit in on some of their meetings, but I -- I
 19 want to take a look at what their protocols are.
 20 What they're -- what they're -- what they're
 21 recommending putting in place before I -- I -- I
 22 comment.
 23 We're aware of it --
 24 MR. DELAGI: Uh-huh.

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 2 MR. BURHANS: -- and -- and we're
 3 aware of it as a barrier, and -- and we're also
 4 cognizant of the EMTALA requirements.
 5 MR. DELAGI: Okay.
 6 DR. HENRY: Well, I -- I -- I'm
 7 wondering out loud, because I was struck by your
 8 prior presentation where there were the spikes in
 9 Tamiflu prescriptions in New York City.
 10 MR. BURHANS: Still ongoing by
 11 the way.
 12 DR. HENRY: But that you had
 13 three spikes that were --
 14 MR. BURHANS: Yeah.
 15 DR. HENRY: -- synonymous with
 16 announcements in the paper and school closings.
 17 MR. BURHANS: Correct.
 18 DR. HENRY: And I'm wondering if
 19 E.M.S. didn't see similar spikes at dispatch. But
 20 the power of the public announcements that go out
 21 is, you know, overwhelming.
 22 MR. BURHANS: They -- they --
 23 they are. And -- and -- and that's why we need to
 24 get ahead of those announcements.

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 2 I think the mayor and the -- and
 3 the health commissioner did a good job of starting
 4 to get ahead of some of those issues yesterday.
 5 Our -- our governor and our
 6 commissioner has been on the road all this week -
 7 Buffalo this morning, Rochester this afternoon,
 8 Syracuse yesterday, Albany the day before - and I
 9 think you'll start seeing some of that public
 10 messaging getting out there, and getting ahead of
 11 some of these issues. That's -- that's what our
 12 plan is. And -- and -- and we hope that the press
 13 is -- is -- well I can tell you. The press picked
 14 them up, because I watched the national news, and
 15 saw Commissioner Farley on the national news, so
 16 they are picking it up, and they are -- they are
 17 getting the message out, which is -- which is good.
 18 I got a couple more minutes
 19 before I got to run. Anything else?
 20 Thank you --
 21 DR. HENRY: I think --
 22 MR. BURHANS: -- for asking me
 23 here.
 24 DR. HENRY: -- I think we've seen

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 2 you -- these announcements. I've certainly seen
 3 stronger messages in the public announcements. Not
 4 to go to emergency departments unless, you know,
 5 it's desperate, so it's important that come higher
 6 up on the screen. Not be number eight, but higher
 7 up there.

8 MR. BURHANS: Yeah. Yeah. And I
 9 think that the messaging is consistent.

10 DR. HENRY: But it has impact.

11 MR. BURHANS: We're saying don't
 12 close schools, and don't go to -- I mean so right
 13 now I think the messages are nice and they're
 14 consistent across the board.

15 And you know, when -- when people
 16 can -- you know, I mean the other thing that I
 17 think is important to note is H1N1 didn't go away
 18 this summer. I mean we continued to have
 19 laboratory-confirmed cases all through the summer,
 20 and we monitored children's camp outbreaks, and we
 21 had over sixteen hundred cases and -- and thirty
 22 outbreaks in children's camps in New York this
 23 summer, so the idea that when it gets hot, the flu
 24 goes away, it wasn't entirely accurate in this

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 2 state. We -- H1N1 is still here and it's
 3 smoldering, and I think when the kids get back
 4 together I think it will start to spark a bit. So,
 5 you know, I think we need to be ready, and I -- I
 6 think that we have more information now than we had
 7 in the spring, and so I think we'll be better
 8 prepared.

9 Any other questions?

10 DR. HENRY: Will you be sharing
 11 the resistance, of -- and the -- of the eight or
 12 nine centers that are testing, are you going to be
 13 sharing what you're seeing, whether it's
 14 traditional flu or H1N1, and what the resistance is
 15 of the two?

16 MR. BURHANS: Yeah. Yeah. The
 17 messages that are going to be coming out from our
 18 clinical management group are basically going to
 19 indicate that the -- the best thing an informed
 20 clinician can do is know what's circulating in his
 21 community. The best way to do that is to go to the
 22 Department of Health's Web site, or the city
 23 Health -- Health Department's Web site and see what
 24 strains are circulating.

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 2 And as -- and as -- if we see
 3 resistance, we will be publishing that information,
 4 so clinicians will know that. Because as you know,
 5 the rapid tests just aren't very effective.
 6 There's a lot of false negatives, and so while it
 7 has some utility -- and I'm not a physician, so I'm
 8 not going to speak any more than that -- while it
 9 has some utility, the bottom line is the best thing
 10 for -- for a physician to do if he has a patient
 11 with I.L.I., and -- and -- and can't rule in strep
 12 or something else, is to assume that it's the
 13 predominate circulating strain.

14 And if we're real lucky, in the
 15 next six months, we'll have H1N1 come back
 16 predominant without seasonal flu, and then we'll
 17 have our seasonal flu spike in February with H1N1
 18 waning.

19 So, that would be like the best
 20 thing that could happen to us, although we'll be
 21 really exhausted by the time April or May comes
 22 this year, because it's -- we're going to have a
 23 very long flu season.

24 I keep telling my staff this is a

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 2 marathon, not a sprint, and I think that's the
 3 truth. So, we need to be prepared for a very, very
 4 long, potentially six-month flu season this year.

5 Yes. But we will be putting that
 6 out there, so clinicians can make empiric
 7 decisions, which is really what they're going to
 8 need to do.

9 DR. HENRY: Thank you very much.

10 MR. BURHANS: Okay. Thanks for
 11 inviting me. And I'll come back if I'm asked.

12 Take care. Thank you all.

13 DR. HENRY: Okay. Donna, would
 14 you put the other members on the list of --?

15 MS. JOHNSON: Yes.

16 DR. HENRY: All right. Let's go
 17 to the committee reports then.

18 Dr. Marshall?

19 DR. MARSHALL: Thank you.

20 Good afternoon, everyone.

21 Medical Standards met this morning, and we had a
 22 lot of good discussion. We have a lot of motions
 23 to bring forward.

24 The first motion -- the first

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1 motion that comes forward is last year we had a
2 presentation from the CARES group, which brought
3 forward information regarding the use of
4 hydrocortisone intravascularly for the treatment
5 acute adrenal insufficiency and -- or Addisonian
6 crisis in certain pediatric patients, primarily
7 that have this entity, and the ability of this
8 medication to provide lifesaving support in the
9 prehospital setting.

10 There was a lot of discussion
11 last time and this time regarding the potential
12 volume of patients with this entity, and the fact
13 that a lot of the parents have this medication at
14 home, and have the ability to administer it,
15 however, a lot of times they may not, and E.M.S.
16 may be called to the scene, and if -- if identified
17 could provide this medication to these patients.

18 The issue was referred to
19 E.M.S.-C. group, which evaluated this and came back
20 with protocol changes, which would provide for the
21 use of hydrocortisone in the prehospital setting
22 for patients who are identified with acute adrenal
23 insufficiency, or Addisonian crisis, and E.M.S.-C.

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1 recommended that SEMAC approve regions to add this
2 to their protocols -- to their regional protocols,
3 and also brought forward to include hydrocortisone
4 into the state formulary.

5 After some discussion this
6 morning, the motion came forward, at -- at this
7 point to add hydrocortisone intravascularly to the
8 state formulary. There was some discussion about
9 whether or not hydrocortisone could be used for
10 reactive airway disease or not, and we got off on
11 two separate tangents there, but we finally came
12 back to the center and wanted some clarification
13 from the E.M.S.-C. group, or wanted to look into
14 the issue or the possibility of replacing
15 Solu-Medrol with Solu-Cortef, but in the meantime
16 we determined that we would add hydrocortisone to
17 the state formulary, and that's what comes forward
18 as a seconded motion to add hydrocortisone to the
19 state formulary.

20 DR. HENRY: Dr. Cooper?

21 DR. COOPER: Dr. Marshall, I
22 think that the approach that Medical Standards took
23 makes -- makes eminent sense. I was made aware of

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1 the discussion that took place earlier in Medical
2 Standards.

3 My apologies for not joining you
4 this morning. I had a couple of surgical
5 emergencies kept me back in the city. But I did
6 have the opportunity to consult with two senior
7 pulmonologists about the -- about the issue.

8 There's little doubt that
9 Solu-Medrol, or methylprednisolone, is the
10 preferred drug for reactive airway disease, because
11 one is dealing with a chronic inflammatory
12 condition that -- that is likely to require that
13 type of approach. In addition, it completely lacks
14 the mineralocorticoid effect that would result in
15 some salt retention and water retention, which
16 would not necessarily be good for a patient with --
17 with acute exacerbation of a respiratory illness.

18 So, the consensus among the folks
19 that I spoke with is that Solu-Medrol would very
20 clearly be preferred for treatment of reactive
21 airway disease, as we all have used it in the past.

22 However, the same is equally true
23 with respect to Solu-Cortef or hydrocortisone. On

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1 the other side, it's -- it is the preferred drug
2 for treatment of acute Addisonian crisis, because
3 it has a very short onset of action, and in fact
4 does have pronounced mineralocorticoid effect, and
5 of course, you know, the -- the cardiovascular
6 collapse is the major issue that one is seeking to
7 prevent in terms of acute Addisonian crisis. So,
8 once again, there's little doubt among the
9 endocrinologist community, that hydrocortisone is
10 the preferred drug for that condition.

11 That having been said -- that
12 having been said, Solu-Medrol has been used, and
13 can be used, okay, as a -- as a -- as a reasonably
14 effective substitute for Solu-Cortef or
15 hydrocortisone in its absence.

16 So, the -- the short of it is
17 that there appears to be little downside and
18 considerable upside in allowing the use of
19 Solu-Medrol for congenital adrenal hyperplasia and
20 similar conditions, when hydrocortisone is not
21 available, but the reverse is not true. It does
22 not appear that -- that hydrocortisone or
23 Solu-Cortef would be the ideal medication for

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 2 patients with -- with either bronchial asthma or
 3 chronic obstructive pulmonary disease, or similar
 4 reactive airway conditions that we encounter so
 5 commonly in the field.

6 DR. HENRY: Okay. Thank you.

7 DR. MARSHALL: Want to vote?

8 DR. HENRY: Well, we can vote.
 9 We can have a sense of the group. We -- we don't
 10 have a quorum, so I don't think a roll call is
 11 necessary, but I think a sense of the committee
 12 might be useful next time, it will facilitate
 13 formal movement.

14 So, we can call ayes and nays, if
 15 you wish for these motions.

16 DR. MARSHALL: All those in favor
 17 say aye.

18 FROM THE FLOOR: Aye.

19 DR. MARSHALL: Opposed?

20 Abstain?

21 Okay. Thank you.

22 DR. DAILEY: The one thing that
 23 Dr. Marshall and I discussed here, sort of as an
 24 aside, is within the documentation that came

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 2 forward from the E.M.S.-C. group, was a reminder
 3 that back in 2003 there was a shortage of both
 4 Solu-Medrol and Solu-Cortef, and many regions
 5 substituted dexamethasone at the time. My
 6 suggestion would be that we also add dexamethasone
 7 to the state formulary, not because of an immediate
 8 expectation for its need, but that that way, we
 9 don't have to bring emergent processes back from
 10 regions should it occur again. So, I would just
 11 ask us to look for that when we have a quorum, or
 12 when our quorum creating members who are currently
 13 nonvetted are allowed to vote.

14 DR. HENRY: Okay. We can look
 15 into oral prednisone, too.

16 DR. MARSHALL: Okay. Moving
 17 right along. The next motion that was discussed
 18 and approved were the Nassau REMAC protocols.
 19 There were two protocols that they brought forward
 20 that had changes. Chest pain, acute M.I. protocol
 21 essentially was the same. They did add just a few
 22 things:

23 One was acquisition of
 24 twelve-lead E.K.G., fluid challenge and transport

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 2 to a P.C.I.-capable facility. That was -- that was
 3 approved.

4 They also had a respiratory
 5 arrest protocol, in which the changes included
 6 utilization of wave -- wave form capnography, and
 7 in their protocol it said "if available," which we
 8 noticed after -- after the vote actually. So,
 9 after some discussion with Nassau that was
 10 recommended that that be approved with removal of
 11 the "if available" language.

12 The second part of that was that
 13 they added the use of laryngeal mask airway or dual
 14 lumen airway device, and there was quite a bit of
 15 discussion on terminology of different types of
 16 airway devices that might be appropriate in -- in
 17 this situation. And in the end -- I think we left
 18 it up to the region to determine what the language
 19 that they wanted to have in there. So, that came
 20 forward under those circumstances.

21 So, utilization of wave form
 22 capnography, with removal of the "if available"
 23 language, the addition of L.M.A. or dual lumen
 24 device. This was put in after -- in their

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 2 protocol -- in their existing protocol, they have a
 3 limit of two attempts at intubation before
 4 transport, and the chest pain protocol with the
 5 changes I mentioned. If you have any questions?

6 Okay. Seeing none, all those in
 7 favor say aye.

8 FROM THE FLOOR: Aye.

9 DR. MARSHALL: Opposed?

10 Abstain?

11 Thank you. The next motion that
 12 was discussed was Dr. Dailey brought forward a
 13 pilot study where they're going to start cooling
 14 people in the field. Under their hypothermia
 15 protocol -- pilot protocol actually, they will
 16 begin cooling patients using chilled normal
 17 saline -- chilled to four degrees centigrade,
 18 transported in a cooler, the manufacturer of which
 19 was not discussed. For all patients who have
 20 return of spontaneous circulation in the field with
 21 a G.C.S. of less than eight and an end-tidal CO2
 22 greater of twenty who have an advanced airway
 23 placed. And these patients will begin receiving
 24 chilled saline at four degrees centigrade, two

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 2 liters I think maximum in the field, and then
 3 transported to a facility that has agreed to
 4 continue the hypothermia treatment protocols in
 5 hospital. And I think to -- to date there are
 6 three hospitals that have agreed so far. So, that
 7 was discussed and approved.

8 So, Dr. Dailey is here if anybody
 9 has any questions on the -- on the protocol. We
 10 have some additional copies if somebody would like
 11 to see it. It's fairly straightforward though.

12 Any questions?

13 DR. HENRY: I think the one thing
 14 that the proposed change was that they agreed to is
 15 that they are going to get I.R.B. approval for
 16 this.

17 DR. MARSHALL: Yes. Yeah.

18 DR. DAILEY: And we're going to
 19 use a registry for all of the arrests.

20 DR. MARSHALL: No questions.

21 All those in favor say aye.

22 FROM THE FLOOR: Aye.

23 DR. MARSHALL: Opposed?

24 Abstain?

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2 Thank you.

3 The next two are -- were really
 4 recommendations which -- some of which we've
 5 already had some discussion on this already in
 6 terms of H1N1 and our response, especially in the
 7 E.M.S. community, and whether or not E.M.S.
 8 providers can - not that they can or can't, that
 9 they can - but would be permitted to vaccinate
 10 patients, or provide patients with antiviral
 11 medications.

12 So, one of the recommendations
 13 after significant discussion came forward, is that
 14 we -- we want to recommend to SEMAC to recommend to
 15 the commissioner that E.M.S. providers be trained
 16 and approved to administer vaccinations and
 17 distribute antivirals, essentially before the need
 18 to do so arises.

19 And there were two parts to this:
 20 One was to enable E.M.S. providers to provide
 21 treatment to their colleagues. And one was to
 22 participate in a public health response to a
 23 pandemic, which would be by administering either
 24 the vaccine or providing antiviral medications to

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 2 patients. That comes forward as a recommendation
 3 from Medical Standards to SEMAC to the
 4 commissioner.

5 Any questions?

6 Okay. So, that was just -- yes,
 7 Dr. Cooper?

8 DR. COOPER: I think everyone who
 9 has had the opportunity to share in these
 10 discussions over the years recognizes that it's
 11 really high time that we take this step. We all
 12 have recognized for many, many years that E.M.S.,
 13 if you will, is our public health infantry, and
 14 if -- if our E.M.S. colleagues are not prepared
 15 to -- to take the first steps in fighting this
 16 pandemic, who is?

17 We need to move forward
 18 immediately with this recommendation to the
 19 commissioner. I'm a little less sanguine about the
 20 first justification, namely treatment of
 21 colleagues, as opposed to treatment of the public.
 22 The -- the diagnosis of -- of which patients may or
 23 may not require treatment can be a little bit
 24 difficult at times, but certainly the overriding

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2 public health concern is -- is -- is apparent to
 3 all, and I really think we should strongly support
 4 this -- this recommendation and advise the
 5 commissioner of our feelings immediately.

6 I don't know if there's an
 7 opportunity, since apparently we do not have a
 8 quorum to make this recommendation known to the
 9 commissioner, in the absence of a quorum. But if
 10 there is such a mechanism, Mr. Chairman, I strongly
 11 suggest that we utilize it.

12 DR. HENRY: Well, not -- not
 13 hearing the prior discussion, part of the idea for
 14 E.M.T.s inoculating themselves was so it could
 15 happen rapidly on multiple shifts, if that was so
 16 the directive, as well as for other people.

17 And the -- part of the notion was
 18 to develop materials similar to the Solu-Cortef
 19 sheet, and other medication administration sheets
 20 that are familiar to us, so we can see them ahead
 21 of time, our educators see them ahead of time, and
 22 if such a time occurs that we are told, yes, this
 23 is a good idea, we're prepared with documents
 24 familiar to us.

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 2 So, we would ask if this goes
 3 through, for people to develop those materials,
 4 give them to the department, and see what SEMSCO
 5 says tomorrow. There can be a -- there can be an
 6 action there that will just transmit them. Okay.
 7 DR. MARSHALL: Yeah. I don't --
 8 well, this is not the first time we've had this
 9 discussion. We've had this over the past several
 10 years as we've gotten closer and closer to a
 11 pandemic. With the bird flu, I think we had the
 12 same discussion, so --.
 13 MR. WRONSKI: If I might comment
 14 Dr. Marshall.
 15 DR. MARSHALL: Yes.
 16 MR. WRONSKI: You're right on
 17 target actually, this body and the SEMSCO, in the
 18 past, has voted to recommend to the commissioner of
 19 health the ability of E.M.S. providers to
 20 vaccinate, and to do other things, and all these
 21 variety of other issues.
 22 In a sense this is, you know, any
 23 vote on this would be simply a reiteration, you
 24 know, in the current scheme of things, but you

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 2 really have already taken that stand and sent them
 3 a letter, I think it was two years, in which was
 4 included. And maybe the development of education
 5 materials, doesn't really require a motion for a
 6 group to, you know, put documents together, but I
 7 think you've already taken a stand on this more
 8 than once before.
 9 DR. MARSHALL: Uh-huh. Yeah.
 10 I -- I agree.
 11 The next topic --.
 12 DR. COOPER: Excuse me, Dr.
 13 Marshall?
 14 DR. MARSHALL: Yes.
 15 DR. COOPER: Still I think it
 16 would be worthwhile stating on the record or
 17 reaffirming our -- our support of that previous
 18 position in the current situation. So, I would
 19 merely ask that you call for an affirmation of that
 20 recommendation.
 21 DR. MARSHALL: Okay. All those
 22 in favor of the recommendation say aye.
 23 FROM THE FLOOR: Aye.
 24 DR. MARSHALL: Opposed?

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 2 Abstain?
 3 DR. MARSHALL: Unanimous. Thank
 4 you.
 5 The next discussion that took
 6 place earlier today centered around ST elevation
 7 M.I. patients who are in cardiac arrest or
 8 post-arrest, who have ST elevation M.I., and the
 9 issue around specialists not wanting to take these
 10 patients to the cath lab perhaps for the patients
 11 who are in critical condition, or perhaps because
 12 of other reports that might be generated as
 13 mortality increases when you take these sicker
 14 patients to the -- to the cath lab.
 15 So, the -- after some discussion,
 16 there was a recommendation that the SEMAC recommend
 17 to the Cardiac Advisory Committee to review their
 18 guidelines on their review of M and Ms for
 19 cardiologists, especially when cardiologists take
 20 these -- these are the sickest patients that we
 21 have, or some of the sickest patients that we have,
 22 that are taken to the hospital that will really
 23 probably or may benefit from cardiac
 24 catheterization and angioplasty, as opposed to --

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 2 in addition to the regular ones who aren't
 3 post-arrest, but certainly we have those patients
 4 that are post-arrest, who would definitely benefit
 5 from going to the cath lab.
 6 So, that was the recommendation,
 7 and the -- the Committee felt that part of why
 8 these patients may not be going to the cath lab is
 9 because of the reporting requirements, and that
 10 these are the really sick patients, and that
 11 specialists might be adverse to taking them for
 12 various reasons, so we wanted to make sure that our
 13 views are transmitted to the Cardiac Advisory
 14 Committee, and that they review their reporting
 15 requirements, especially for these sick, sick
 16 patients.
 17 Any questions?
 18 Dr. Dailey?
 19 DR. DAILEY: Just as a little
 20 background, the presence of cardiogenic shock is
 21 one of the things that's reportable under the
 22 current guidelines. However, ST elevation M.I.,
 23 elevated troponins and status post-cardiac arrest
 24 or ROSC, are all actually considered exactly the

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 2 same way in the current reporting system.
 3 So, if a patient has a non-ST
 4 elevation M.I. and has normal blood pressure, or
 5 has return of spontaneous circulation after cardiac
 6 arrest and has a normal blood pressure, those two
 7 patients are considered exactly the same for the
 8 statistics of that interventional cardiologist.

9 So, the suggestion being that
 10 this group ask the Cardiac Advisory Committee to
 11 revise those guidelines, to make sure that our
 12 E.M.S. patients who are the sickest of the sick,
 13 and not yet in cardiogenic shock, get the benefit
 14 of P.C.I. as quickly as possible in the course of
 15 their disease to enhance survivability, while we're
 16 also continuing to promulgate ideas of therapeutic
 17 hypothermia to improve outcomes for these patients.

18 Just trying to make sure as many
 19 things are in place as possible, and protecting our
 20 colleagues in cardiology.

21 DR. MARSHALL: Any other
 22 questions on that?

23 All right. We had some other
 24 discussion. The Bureau of Narcotic Enforcement

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 2 is -- is still working on ketamine and answering
 3 some questions that they had, so hopefully we'll
 4 hear something at the next meeting.

5 We also had some information from
 6 Dr. Young about stroke and -- and telestroke -- the
 7 telestroke model. I don't know if he wants to do
 8 it here, but some of the things they were talking
 9 about were some of the systems in the state that
 10 have this telestroke model, and some of the data
 11 that's going to be presented to the C.D.C., I
 12 believe, in terms of looking at what's being done
 13 in these hub and spoke facilities, and what are
 14 some of the newer techniques for treating patients
 15 with stroke.

16 Some of the statistics that Dr.
 17 Young brought was from 2006 to 2008, there were two
 18 hundred and forty-one consults done using this
 19 telestroke process, and out of that nine point two
 20 percent got T.P.A. There was a high transfer rate,
 21 which was something that they weren't expecting, so
 22 there was a lot of discussion about what are the
 23 potential reasons that patients might be
 24 transferred from the spoke to the hub hospital?

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 2 And so, we discussed some of those reasons, and
 3 some of the -- their actually doing survey or they
 4 did a survey and they're collecting more data.

5 MR. WRONSKI: They -- they
 6 have -- they've done the survey, and what they're
 7 doing is they're analyzing it, it's not -- they've
 8 not finished going through the data.

9 DR. MARSHALL: Right. They're
 10 also looking at some of the newer endovascular
 11 techniques that -- that may account for some
 12 patients who are candidates for T.P.A., but don't
 13 get T.P.A. And I know that New York City there's
 14 also a facility that's looking at some of these new
 15 procedures -- endovascular procedures for treating
 16 stroke.

17 There was also some discussion
 18 about patients who are in the state protocol and
 19 the transportation of patients who are in traumatic
 20 arrest in the field, and the guidelines that are
 21 the protocols that are require patients who are in
 22 traumatic cardiac arrest be taken to the nearest
 23 facility, but whether or not these patients might
 24 actually benefit better from going to a trauma

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 2 center and we discussed issues about how far the
 3 trauma center might be from the community hospital,
 4 if ten minutes was an adequate time frame?

5 I guess it's kind of like the New
 6 York City ten-minute rule, where you can go to the
 7 next closest hospital as long as it's no more than
 8 ten minutes from the closest hospital.

9 And then, we also talked about
 10 that in relation to the air medical transport, and
 11 would it be prudent to go an additional ten minutes
 12 to go from a level-two to a level-one trauma
 13 facility using air medical transport. Not that
 14 patients who were in traumatic arrest should get
 15 into a helicopter, but that was certainly
 16 discussed.

17 We also discussed time to getting
 18 to a surgeon; blunt versus penetrating trauma; and
 19 in the end, we recommend that this issue be
 20 forwarded to the State Trauma Advisory Committee
 21 for their input, to see what they think about this
 22 transportation and triage issue of trauma patients
 23 who are actually traumatic arrest patients --
 24 traumatic arrest in the field.

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 2 We also discussed, you know, how
 3 long were the patients in arrest -- would that make
 4 a difference if they were, you know, if they got
 5 return of spontaneous circulation.

6 There was also some discussion
 7 about pediatric trauma -- pediatric traumatic
 8 arrest, I guess, because not every regional trauma
 9 center is a pediatric trauma center. So, those are
 10 also some of the issues that we recommend be
 11 forwarded to the State Trauma Advisory Committee
 12 for their -- their position on that.

13 DR. COOPER: Dr. Marshall?

14 DR. MARSHALL: Yes.

15 DR. COOPER: The American College
 16 of Surgeon's Committee on Trauma has prepared a
 17 position statement, I believe in collaboration with
 18 the National Association of E.M.S. Physicians,
 19 on -- on termination -- on termination of
 20 resuscitation for patients in traumatic cardiac
 21 arrest in the field. That document specifically
 22 pertains to adult patients, but a similar document
 23 is being finalized right now that -- that pertains
 24 to pediatric patients. Those documents may be

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 2 useful in terms of providing some guidance, both to
 3 the SEMAC as well as the STAC.

4 DR. MARSHALL: Well, thank you.
 5 Maybe we can get ahold of those and distribute
 6 them.

7 There was also an update on the
 8 blood use -- E.M.S. administration of blood, and --
 9 and Mr. Wronski, do you want to make some comments
 10 about that?

11 MR. WRONSKI: Sure. The staff
 12 have been working on a regular basis with -- with
 13 Dr. Linden and her staff, on the regulations which
 14 were finalized and approved by the Blood Council at
 15 that level, and are with our division of legal
 16 affairs right now for final sign-off. And from
 17 there it would go back to the Blood Council for
 18 approval, and then into the regulatory -- final
 19 regulatory approval process. But right now,
 20 they're being reviewed one last time by the
 21 division of legal affairs.

22 But a lot of progress has, you
 23 know, been made and we are working on the
 24 educational documents and -- and protocols, not

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 2 waiting for approval of the regulations.

3 DR. MARSHALL: Okay. And that's
 4 my report. And we did that, and only went over by
 5 about five minutes.

6 DR. HENRY: Good job.

7 Dr. Kauffman, Mr. Delagi. Do you
 8 have anything to bring forward from the quality
 9 perspective?

10 MR. DELAGI: No motions to bring
 11 forward but we do have a brief report from our
 12 meeting earlier today. At the beginning of the
 13 meeting, everybody kind of issued the same
 14 disclaimer that our committee was a little bit
 15 stalled over the summer in lieu of all the
 16 influenza planning that we've been undertaking at
 17 state and local levels, but nonetheless we -- we
 18 did find progress in certain areas.

19 Staff reported that the
 20 department of legal affairs and the hospital
 21 preparedness folks are still reviewing a draft of
 22 the letter of hospital C.E.O.s encouraging
 23 participation between hospitals and E.M.S. agencies
 24 in the Q.I. process. You remember that we

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 2 discussed at our meetings in June. And I think
 3 part of the issue right now is that we're at a
 4 crossroads between this request and the 405 Regs
 5 undergoing concurrent changes related to Q.I. and
 6 STEMI center designation.

7 So, there's a reluctance I
 8 think -- and I don't mean that in a bad way, but a
 9 reluctance to -- to commit to certain agreements
 10 between hospitals and E.M.S. agencies on Q.I.,
 11 until those regs are flushed out. So, there is
 12 progress there, and -- and we do expect to have
 13 something soon. The Bureau also prepared a very
 14 well-thought-out document consisting of all of the
 15 clinical data points that are in the NEMESIS data
 16 set. You will remember that in order to achieve
 17 NEMESIS gold status, a vendor has to collect four
 18 hundred and seventy-nine data elements -- that's
 19 incredible -- between clinical and demographic
 20 information.

21 So, our charge is to review that
 22 document with an eye towards what we believe
 23 version six of the statewide P.C.R. should look
 24 like with the addition of -- of some -- some

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 2 clinical data points that we're currently not
 3 connecting -- collecting, and our committee has
 4 decided to add the mandatory NEMSIS clinical
 5 elements, of which there are ninety, to the current
 6 list of data elements we collect on the statewide
 7 P.C.R., circulate that for committee review, and
 8 then discuss that at our next meeting. And we do
 9 have a work process identified for that offline
 10 that we will participate in between now and our
 11 next meeting.

12 We report progress on grant year
 13 one of the governor's highway traffic safety board
 14 grant which allows the -- the state to look at all
 15 of the electronic data reporting formats in use
 16 across the state with an eye towards developing a
 17 platform for receiving electronic data in year
 18 three from a variety of different sources.

19 On the ACEP report card, limited
 20 progress there. We did receive some positive
 21 feedback from the SEMAC and the SEMSCO on the
 22 analysis and the recommendations that we put forth
 23 to you at our last meeting, and likewise limited
 24 progress on the New York State data points.

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 2 We hope to pick up the pace on that pretty soon.
 3 We did receive the final reports
 4 from the respective program agencies for their
 5 program agency contract deliverable annual focus
 6 studies, and we reviewed the -- the subject
 7 material that was actually reviewed in each of the
 8 respective regions. And we're going to undertake a
 9 project to design a spreadsheet to document the
 10 annual studies that are done every single year.

11 To be very, very clear, we are
 12 not going to be reporting the Q.I. findings of the
 13 respective regions. We are very simply going to
 14 put together a spreadsheet to document the
 15 respective Q.I. programs that have taken place over
 16 the last several years and going forward, to
 17 whenever we see fit to not do it anymore, in an
 18 effort to generate a database of what regions are
 19 doing to identify best practices, both for the
 20 regional level and the agency level, so that we can
 21 put an addendum out to the Q.I. manual, and give
 22 people some focused direction on what they could be
 23 studying regionally and at the service level.

24 No new discussions on the online

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 2 medical control discussion.
 3 And then, under new business, we
 4 had been awaiting the release of the N.T.S.B.
 5 document on air medical safety. It's kind of part
 6 safety oriented and part financial oriented. And
 7 so, we propose to sit down with the air medical
 8 group, and actually take a look at the N.T.S.B.
 9 document to see if it has any applicability to air
 10 medical use and protocols.

11 You will recall that this was a
 12 process that began after a spate of air craft
 13 collisions over the last twelve to sixteen months,
 14 and we're going to take a look at that document,
 15 and -- and see what applicability that has to our
 16 use of air medical services here.

17 Dr. Kauffman, anything to add?

18 DR. HENRY: Okay. Any discussion
 19 or questions?

20 MR. WRONSKI: Just -- just one
 21 thing. I -- I applaud all the work your committee
 22 does, and -- and the cochairmanship seems to work.
 23 The -- so, it's appreciated. I particularly
 24 appreciate the progress where we're heading with

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 2 NEMSIS. I think that's one of the more important
 3 things from a system Q.I. perspective that will
 4 happen over the next two to three years, is decide
 5 what the New York State database should look like,
 6 and move us from the -- the ninety elements, and --
 7 and you know, very clearly we're going to add some
 8 elements. We're not going to go to four hundred.
 9 We're not going to go to three hundred. Do we go
 10 to two hundred? I guess it depends who is on the
 11 committee.

12 The -- but clearly there's a
 13 number of other elements that should be added, and
 14 everybody I think can -- will agree to that.

15 And in tandem, the department is
 16 developing, through the bureau and the governor's
 17 highway grant, the capability of taking that data,
 18 on a contemporary basis, and then putting it out
 19 there with reports, and that will be the benefit
 20 that we have both of these projects going on
 21 simultaneously.

22 And so, in two to three years,
 23 you know, you may actually begin to see statewide
 24 data available and analyzed and in your hands to

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 2 look at. So, great work.
 3 DR. COOPER: I think we all
 4 recognize that, you know, NEMSIS has been a major
 5 step forward in terms of the effort to collect
 6 nationwide E.M.S. data.
 7 The contrast with the national
 8 trauma data set, however, could not be more
 9 striking. The -- the trauma community, in
 10 partnership with the federal government, has moved
 11 toward a much leaner data set than -- than NEMSIS
 12 has -- has embraced.
 13 The national trauma data set
 14 embraces no more than about seventy-five elements
 15 in toto, whereas, of course, NEMSIS, as you have
 16 heard, embraces over four hundred different
 17 elements.
 18 I -- we all, of course,
 19 understand that progress can't be made without
 20 data, and the -- the more data that we can collect
 21 that is -- that is useful and is used, the better
 22 off we are in terms of improving the system. But
 23 it -- it might be worse our querying perhaps
 24 through the National Association of State E.M.S.

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 2 officials, either the medical directors' group, Dr.
 3 Henry, or the -- or the main body, Mr. Wronski, to
 4 find out, from other state E.M.S. directors and
 5 medical directors, if all this data is being used.
 6 And that may, I think, lead to a
 7 discussion as to the value that is gained from some
 8 of the more minor data elements that have been
 9 recommended and perhaps -- I don't know, perhaps
 10 bronze is gold and gold is bronze in the real
 11 world, because if you're collecting four hundred
 12 data elements, the chances are you're not using at
 13 least some of them.
 14 But I think it's a question that
 15 really -- that we really do need to ask in -- in
 16 New York State. We all recognize the -- the
 17 difficulty of recruiting and retaining volunteers,
 18 and asking them to -- to fill out a data sheet of
 19 some four hundred elements after every run, to me,
 20 perhaps might be barking up the wrong tree.
 21 MR. WRONSKI: We -- we have asked
 22 the question of a variety of sources, including the
 23 federal government home for NEMSIS in -- remind me,
 24 Lee, is it Oregon?

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 2 DR. COOPER: I was going to say
 3 North Carolina.
 4 MR. WRONSKI: No. Who is -- yes,
 5 the NEMSIS?
 6 DR. COOPER: Greg Mierce
 7 (phonetic spelling).
 8 MR. WRONSKI: Greg Mierce, yes.
 9 DR. COOPER: North Carolina, I
 10 believe.
 11 MR. WRONSKI: North Carolina?
 12 All right.
 13 DR. COOPER: I think so.
 14 MR. WRONSKI: We have worked with
 15 them. We've asked them -- I, during my time with
 16 the national directors have asked separate state
 17 directors. But the national groups, when Ms. Burns
 18 and Ms. Gokey (phonetic spelling) asked them, you
 19 know, how many states use the data -- not use the
 20 data. How many states are compliant with the data?
 21 Not many.
 22 Okay. Although there are --
 23 everybody is signed off, and New York I believe,
 24 was the last one to sign on, for very specific

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 2 purposes, the -- but we are signed on now to become
 3 NEMSIS-compliant.
 4 DR. COOPER: Uh-huh.
 5 MR. WRONSKI: The majority --
 6 more -- more than a simple majority, the large
 7 majority of states are not actively
 8 NEMSIS-compliant right now. They're doing what
 9 we're doing, which is working towards
 10 NEMSIS-compliant. I am unaware of any state that
 11 collects four hundred data points.
 12 DR. COOPER: Right.
 13 MR. WRONSKI: What -- what you
 14 had in the collection was the input of many, many
 15 different people, who said, "this would be great to
 16 have." And maybe would be for them. But not
 17 necessarily for the state or the system.
 18 This is why the Q.I./Q.A.
 19 committee is so important. You have to determine
 20 what makes sense for you.
 21 DR. COOPER: Uh-huh.
 22 MR. WRONSKI: And then, you share
 23 that -- those drafts with the SEMAC and the -- and
 24 the state E.M.S. Council, so that we can come to a

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 2 balance --
 3 DR. COOPER: Uh-huh.
 4 MR. WRONSKI: -- of what makes
 5 sense to spend time collecting.
 6 MR. DELAGI: Absolutely. And Dr.
 7 Cooper's comments are things that were discussed
 8 about at -- at the committee level.
 9 And just so we're clear, the
 10 gold, silver and bronze rating is a marketing
 11 strategy on the vendors with the presumption that,
 12 you know, you know, if you want to sell your
 13 product, gold is better than silver.
 14 The reality is that of the four
 15 hundred and seventy-nine data points, only ninety
 16 of them are necessary to achieve NEMESIS compliance
 17 as a state. And that's what we seek to do. We're
 18 not looking to record a lot of these, you know,
 19 ambiguous and -- and really meaningless data
 20 elements. But ninety out of the four seventy-nine
 21 is the minimum and we're pretty close to that now
 22 already. I forget what the actual number is, but
 23 we don't have far to go.
 24 MR. WRONSKI: Right. And -- and

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 2 again as -- as the committee works through this,
 3 you know, you may wind up with a hundred and twenty
 4 data elements or a hundred and ten. But -- but it
 5 should be based on questions you've asked in the
 6 last decade --
 7 MR. DELAGI: Uh-huh.
 8 MR. WRONSKI: -- you know, and
 9 what answers to. And so, okay, what are the data
 10 elements that you need to answer those questions?
 11 But they should be of
 12 significance to the state and regions, not
 13 necessarily to one individual, one pet project.
 14 It -- it really needs to have significance that it
 15 can be maintained. It's something you would look
 16 at on a regular basis.
 17 MR. DELAGI: Understood.
 18 MR. WRONSKI: So -- and I -- and
 19 I know you do, Bob.
 20 But again most states are not
 21 NEMESIS-compliant. I don't know of anyone with four
 22 hundred or more data elements. And so -- and we'll
 23 continue to ask questions in the national group
 24 to -- to see if they can share with us, as we move

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 2 along, any success stories that -- that really
 3 work. I will tell you that when we told them that
 4 we would be sharing data with them even prior to
 5 becoming NEMESIS-compliant, they were very willing
 6 to take our dinosaur data and drop it into their
 7 database, because it's more data than they
 8 currently have at a national level. So, even
 9 though our data is clunky, it doesn't contain
 10 everything, it -- it is data that can be very, very
 11 useful. So, anyway, thank you again.
 12 DR. HENRY: All right. Thank
 13 you.
 14 Is there anything from the
 15 Education Committee that should come to our
 16 attention now?
 17 Okay. Let's go to staff report.
 18 MR. WRONSKI: Thank you.
 19 It's been a long day for all of
 20 you, so I'll -- I'll try to make this brief. We've
 21 covered some of the issues. The organ donation
 22 pilot. The H1N1 and preparation for that.
 23 A couple of things. Just so you
 24 know, we -- we have completed a revised policy that

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 2 will address, specifically E.M.S. and H1N1, a
 3 couple of weeks ago. It's been in a review process
 4 of these committees that Bob Burhans showed you,
 5 and we're -- we're trying to kick it out of the
 6 final sign-off. We have had the epidemiologists
 7 look at it and they are happy with it. And once we
 8 get that sign-off we will release that policy.
 9 It's not going to contain
 10 information that you don't already know. It's
 11 information that's been out there in the press.
 12 It's information we talked about in the spring.
 13 It's information we've talked about in handling flu
 14 ten years ago. It's not a tremendous amount of new
 15 information, but we will include in it useful
 16 information for E.M.S. providers to go to, to get
 17 updates and pay attention to the evolving, you
 18 know, strain of flu this year. But that's
 19 completed. It has been completed. We're just
 20 waiting for the okay to release it.
 21 We also have been given some
 22 dollars recently to develop a train the trainer
 23 program, which we have largely completed. What
 24 happened is staff did such a good job at it, that

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 2 the education committee - I think that's what it's
 3 called - of these groups wants to use it as a model
 4 for all other healthcare providers, and they're
 5 playing with it, so that we're consistent across
 6 what we send out as a train the trainer has some
 7 basis consistency for other healthcare groups as
 8 well.

9 And we're working with them, and
 10 hope to have that final sign-off, so that we can
 11 deliver a train the trainer program in three or
 12 four meetings across the state, and then trainers
 13 can go out to agencies or -- or within the county
 14 and provide training to E.M.S. agency members,
 15 really aimed not so much at H1N1 -- of course,
 16 we'll discuss that, but more on infectious disease
 17 control practices, fit testing, and we have money
 18 that we're using to purchase fit testing equipment
 19 that would be given to attendees.

20 And my -- my original goal was
 21 hope -- I had hoped that we would have this begun
 22 at the end of August, the first session. But
 23 because so many things have changed and we need
 24 this final sign-off, probably if -- if -- if we get

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 2 approval within the next week or so, then you might
 3 see the first course maybe in the third week of
 4 September.

5 And we'll identify where to hold
 6 that, and -- and -- and send out invites to
 7 trainers and educators. And we will have a certain
 8 criteria of the type of person we want in the train
 9 the trainer. Someone who has some educational
 10 background, and -- and can take in this material.
 11 And then, who is willing to go out and do train the
 12 trainer, which we'll pay for. I mean a training
 13 session, which we'll pay for.

14 So, I'm hoping that can be all
 15 cleared and in place and begun in September.

16 Any questions on that?

17 A couple of things. I -- I
 18 promised a letter to hospitals on training. I have
 19 to tell you that it's become very complex. I've
 20 done a number of drafts. I have a draft on my
 21 desk, which I'm still working on, and it's not
 22 done, but I give you my word I will have that out
 23 before I retire.

24 The -- you've heard about the

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 2 Blood Regs, and -- and the sharing of the E.M.S.
 3 data between hospitals and E.M.S., and what's been
 4 going on there. And I -- I -- again, all those
 5 issues are ones that we've had on the table for
 6 awhile, but I do seem them finalizing over the next
 7 few months. Some of them though, like NEMSIS and
 8 that, will take a lot longer.

9 My last staff report is the
 10 status of the state director. There's rumors of my
 11 impending retirement, and they're true.

12 No, Dr. Kauffman, not death, so
 13 don't call the -- don't call that team yet.

14 But I am going to retire and I
 15 wanted to make that announcement here and at the
 16 state council. I wish I could have done it with
 17 both groups sitting in the same room, although many
 18 of you are, but I didn't want to miss the
 19 opportunity to tell you that I will be leaving the
 20 state service. I've been a state public servant,
 21 and that's the term I use for my career, for
 22 thirty-five years. And thirty-five years is a long
 23 time, and it's time to move on.

24 And ask me where I'm going to

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 2 move on to? I'm going to the backyard and grow my
 3 tomatoes.

4 FROM THE FLOOR: It's a little
 5 late in the season.

6 MR. WRONSKI: It's a little late,
 7 that's true, but -- and it wasn't a good tomato
 8 crop earlier this year either, but I'll improve
 9 with -- with the retirement time I can spend on
 10 them.

11 I have -- I have plans, most of
 12 them on a personal nature. Whether or not I remain
 13 involved in the world of work, as my - my original
 14 job with the state was as an employment
 15 interviewer, and that's what we called it, the
 16 world of work, that's an archaic title, but
 17 thirty-five years ago, it was an up and coming term
 18 in the employment industry - but I wanted to
 19 personally thank you for many years of fulfillment,
 20 and my -- I've already had my talk with staff, but
 21 all of you are incredible people. People I've
 22 worked with since the early '90s who are not here,
 23 they gave their time and years to me when I was
 24 learning what this was all about.

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 2 Mark's been here since the
 3 beginning, which has been very, very good for me
 4 because he's been an anchor. But many of you at
 5 this table have been here a long time, too, and
 6 those of you who have not been here a long time, I
 7 want you to stay a long time.

8 And I'm not saying put in
 9 thirty-five years at the SEMAC, but certainly it's
 10 beneficial for you to stay here, because it's --
 11 it's a rare forum. You don't see this around the
 12 country quite like this where you not only have a
 13 statewide body, but the statewide body then has a
 14 regional body and a home where you can take the
 15 information that you've developed up here, and the
 16 protocols, and bring them back to the region and
 17 modify them and fit your home.

18 And that doesn't happen
 19 everywhere quite like in New York. There are few
 20 states that have that, but not everybody. I think
 21 you do an incredible job at it. I think you keep
 22 us on our toes at the bureaucratic level. You
 23 remind it us we didn't write and do. But you do it
 24 in a way that's professional, and I appreciate

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 2 that. And we couldn't get our work done without
 3 you, and -- and I'm very thankful for that.

4 Work's not over. There's a lot
 5 left on the table. I wish some of the things were
 6 done already. Things that I've, you know, I've put
 7 my efforts into over the years, but -- such as the
 8 database, I had hoped that we would have an E.M.S.
 9 contemporary database already, but we don't. But
 10 we're making huge progress now. And you can
 11 actually see the light at the end of the tunnel for
 12 that.

13 The -- but you know what you're
 14 issues are. They sometimes change, and as many of
 15 you have been here for many years, sometimes they
 16 don't, and -- and they come back for revisiting in
 17 any given year.

18 But again, you'll ask me the
 19 date. Formally, my last week in state service is
 20 Christmas week, so Merry Christmas, but my last day
 21 of work will be probably during the Thanksgiving
 22 week, because I'll be liquidating some time. When
 23 you're around thirty-five years, you tend to save a
 24 lot of vacation, you don't use it all. But I will

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 2 be here actively, other than a few days off, during
 3 most of that time until the end of November.

4 So, again I wish you all well and
 5 thank you very, very much.

6 DR. HENRY: Well, Ed, I -- you
 7 know, you took us a bit by surprise here, and I'm
 8 sure you're going to hear a lot from us, but I
 9 think I speak for all of us from saying that you've
 10 brought a sense of professionalism to E.M.S. over
 11 and above, you know, what it's been in the past.
 12 Not that it wasn't high, but you've raised it even
 13 higher. You've taken on more and more
 14 responsibility in the Bureau.

15 When you think about the trauma
 16 programs administered from the E.M.S. Bureau, now
 17 we have E.M.S. for C., we have added
 18 responsibilities for SEMAC. You've had to do it
 19 with less people, through governor after governor,
 20 and you've done it with a lot of class, and we --
 21 we're all very grateful and the People of New York
 22 should be very grateful for your service.

23 Is there any unfinished business?

24 Is there any new business?

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 2 Okay. Great.

3 DR. COOLEY: Again, I'd like to
 4 echo what Mark said as well, that clearly you've
 5 been a leader and caused some of us to hang around,
 6 and even converted some of us to the dark side of
 7 the force as well, so I -- I think I thank you for
 8 that.

9 The -- this is more or less just
 10 for information. We're sending out a health
 11 advisory Friday, but I wanted to bring it before
 12 the SEMAC members first. This is a combination
 13 from D.O.H. and OASAS, the Office of Alcoholism and
 14 Substance Abuse Services.

15 And essentially what we've seen
 16 is there's a major chance for us to get involved in
 17 the care of individuals that tend to fall through
 18 the cracks, mainly those who are habituated to a
 19 number of different medications. And we sometimes
 20 see them as drug overdoses, we see them as drug
 21 ingestions, maybe they've taken too much, or they
 22 come in with an altered mental status that clears
 23 up fairly quickly, and if -- if they're
 24 significantly ill they're admitted to the facility

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2 and that's sort of where our role ends once they're
3 up on the floors. But we do send people home from
4 the department. And what we're finding is there's
5 an awful lot of these individuals that really get
6 lost to follow-up, and they come back in repeating
7 their -- their presentations to our department, or
8 they'll come -- come in seeking pain medication,
9 and it's clearly an issue of habituation.

10 There are a number of options,
11 and this little note was cut down from its
12 original, but there's a similar one going out to
13 OASAS with all sorts of links, so there's stuff
14 available in most communities, and if you call
15 you're discharge planners, your patient care
16 managers, a lot of them can tie into these systems
17 to try to get individuals the support they need so
18 they don't keep coming back in.

19 So, we do have an option to -- to
20 deal with that. Also, the -- the Academy of Family
21 Practice in New York State has a number of their
22 individuals who are addictionologists who do -- who
23 do that as their primary practice, and they'd be to
24 come to your local REMACs. I suggest that they use

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2 that body to kind of plug into your regional
3 systems, because it is going to vary a little bit
4 in different areas of the state. So, you can maybe
5 make some linkages, and so you can understand just
6 how many of them are out there and are willing to
7 take these patients on, who many times that we wind
8 up with having to beg, borrow and steal to try to
9 get them in to some sort of a program.

10 We also pointed out to the folks
11 drafting these advisories that we do try, and of
12 course, a lot of times we will arrange visits and
13 these folks just tend not to show up, so they
14 understand that. But given that, there still a
15 small percentage that they think that we can
16 benefit. Hence the advisory.

17 So, if there's any -- it really
18 is pretty straightforward. If there's any
19 questions, I'd be happy to address them as best I
20 can.

21 Okay. Thank you, Mark.

22 DR. HENRY: Okay. Thank you. Is
23 there any other new business?

24 Well, then hearing none, the next

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2 meeting is December 1st, and we'll -- we'll
3 adjourn.

4 Thank you all for coming.
5 (The meeting concluded at 4:00
6 p.m.)

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2 I, G. Michael France, do hereby certify that the
3 foregoing was taken by me, in the cause, at the time
4 and place, as stated in the caption hereto, at Page 1
5 hereof; that the foregoing typewritten transcription,
6 consisting of pages number 1 to 103, inclusive, is a
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