

NEW YORK STATE
DEPARTMENT OF HEALTH

MEDICAL STANDARDS COMMITTEE

December 2, 2008
8:00 a.m. - 10:48 a.m.
Best Western Sovereign Hotel
1228 Western Avenue
Albany, New York

APPEARANCES:

Lewis Marshall, M.D., Chair
Paul Bishop
John Broderick, M.D.
Sharon Chiumento
Craig Cooley, M.D.
Heidi Cordi, M.D.
Michael Dailey, M.D.
Robert Delagi
Marie Diglio
Donald Duvall
Debbie Fults
Deborah Funk, M.D.
Timothy Haydock, M.D.
Mark Henry, M.D.
Andy Johnson
Bradley Kaufman, M.D.

Joshua Kugler, M.D.
August Leinhart, M.D.
Martin Masarech, M.D.
Jeffrey Myers, D.O.
Katherine O'Connor
Daniel Olsson, D.O.
Patricia O'Neill, M.D.
Storm Treanor
Craig Van Roekens, M.D.
Edward Wronski

Mark Zeek

1 DR. MARSHALL: We'll go
2 on the record. Implementation.

3 DR. MYERS: So the
4 equipment, we actually were able to
5 secure a grant to equip 15 units
6 with a vehicle cooler for saline.
7 The -- actually, the additional ice
8 packs are something that the
9 services are able to bear very
10 easily, and then buy the tympanic
11 thermometers. The coolers are
12 somewhat in the range of \$300 or
13 \$400 apiece. The thermometers are
14 fairly inexpensive, and as well as
15 the ice packs.

16 Next one. In terms of the
17 training, the training is going to
18 be protocol-based training, a
19 little bit -- very similar to what
20 I briefly presented to you here in
21 terms of why we want to do it, what
22 the benefit is, go through the
23 protocol in much more depth, and
24 then talk about the specific

1 equipment and the maintenance that
2 has to occur on that equipment.

3 Then we're also outreaching
4 to the emergency departments,
5 especially in the hospitals that
6 are not developing their internal
7 program at this point in time, to,
8 one, let them know that these
9 patients are coming in, and two,
10 what to do in the emergency
11 department to continue cooling.

12 Part of the regional review
13 that we needed to go through when
14 we submitted the protocols for
15 approval back in September, all the
16 hospitals in the region have
17 already seen this, and we actually
18 got back several positive
19 protocols -- I'm sorry, several
20 positive comments from hospitals
21 saying, hey, this is a great idea.
22 I'm glad you're doing this. Can I
23 have your hospital protocol?
24 Because they wanted it implemented

1 in their hospital.

2 Next slide. In terms of
3 quality improvement and oversight,
4 what we're going to ask the
5 services that initiate this process
6 to do is have a service and medical
7 director 100 hundred percent review
8 of the first six months of cases
9 and then submit that to our REMAC
10 for an evaluation.

11 Our REMAC is going to review
12 these cases to work to try to link
13 up the outcomes with the hospital
14 so we can see what these patients
15 are doing, at least at discharge.

16 I think that's it for my
17 presentation.

18 MR. WRONSKI: And it's
19 also a recommendation, depending
20 where the body goes on this, but it
21 sounds like at this point, though,
22 you haven't had a meeting with the
23 area hospital leadership to discuss
24 their role in this.

1 Am I wrong on that or would
2 that be right?

3 DR. MYERS: Partially.
4 The doctor has reached out to
5 several of the Buffalo hospitals
6 that are developing programs and
7 there's been a lot of conversations
8 there.

9 In terms of a formal meeting
10 with the hospitals, no, not yet,
11 but that's obviously something
12 we're going to need to do as part
13 of the protocol rollout.

14 MR. WRONSKI: What my
15 understanding is -- Dr. Kaufman can
16 correct me on this -- is New York
17 City, and I think this is how the
18 other programs in the country are
19 working, they try to form a
20 partnership with the EMS and their
21 local hospitals.

22 What hospitals, for instance,
23 would be willing to implement, you
24 know, the cooling protocol within

1 their own hospital and be capable
2 of it. In New York City they've
3 asked -- they've opened the door to
4 any hospital, all right, who is
5 willing also to commit to the
6 cooling process, so it's
7 continuous. Because I believe the
8 literature suggests they really
9 need to continue this process
10 through it.

11 DR. MYERS: Right.

12 MR. WRONSKI: So I'd like
13 to know that that is definitely
14 going to be part of your plan and
15 process for implementation so that
16 we have the hospitals buying in.

17 DR. MYERS: The four PCI
18 capable hospitals -- I don't want
19 to call them PCI centers -- the
20 four PCI capable hospitals have
21 either started cooling or are in
22 the preparation to continue that
23 cooling. Those are also the way
24 that -- the way that referral

1 patterns occur in the western New
2 York region, those are also the
3 hospitals that will end up
4 receiving these patients if they
5 survive.

6 My experience has been --
7 again, I don't have the data to
8 back this up, but my experience has
9 been that if we do have a survivor
10 of out-of-hospital cardiac arrest,
11 they tend to end up being
12 transferred to one of those four
13 hospitals.

14 DR. MARSHALL:

15 Dr. Kaufman had his hand up, and
16 then we'll go around the table.

17 DR. KAUFMAN: In New York
18 City we're obviously working very
19 hard to do the same thing. It's
20 fantastic how much progress you
21 guys have made. I guess a few
22 questions really to help us inform
23 New York City and maybe to get
24 everybody's input on it. Start

1 with -- in the EMS process, the
2 patient selection, I guess, are you
3 going -- you know, you said you're
4 not including pediatric or pregnant
5 patients. Do they have to be
6 patients of primary cardiac
7 etiology arrest or are you going to
8 include primary respiratory
9 arrests, drownings?

10 Those are some of the
11 issues we've been dealing with.
12 Because only about 60 percent, 70
13 percent of the patients are
14 presumed to have an arrest of
15 primary cardiac etiology.

16 DR. MYERS: Right. It
17 may be difficult, it's oftentimes
18 difficult in the field and even in
19 the emergency department to nail
20 this down initially what the
21 primary cause of that arrest was.
22 We're not specifying that it has to
23 be a primary cardiac event or
24 believed cardiac event. That may

1 complicate things too much.

2 DR. KAUFMAN: Right.

3 Those studies -- primary cardiac --
4 we also -- we're going to try and
5 branch this out to a larger group
6 to include respiratory traumatic
7 trauma, and so on.

8 DR. MYERS: And I think
9 with the review, if we see that
10 those patients are not -- you know,
11 it's not effective, are not doing
12 well, we can refine that as we go
13 along.

14 DR. KAUFMAN: Right. And
15 then something else we're looking
16 into, I don't know if you're --
17 we're going to hopefully start, our
18 first phase is going to be just
19 transporting to a hospital that can
20 do cooling, but we're going to do
21 Phase 2, which is the prehospital
22 cooling. We're hoping to actually
23 start that during the arrest. It
24 sounds like you're going to start

1 that only with boxed patients. We
2 plan on giving cold saline with the
3 arrest, realizing many of those
4 patients will never come back.
5 However, if they do --

6 DR. MYERS: That's
7 excellent. We've got a very
8 complementary thing. I'll be very
9 excited to compare data.

10 DR. KAUFMAN: Yeah.
11 Actually, the other major problem,
12 as Mr. Wronski was alluding to,
13 hospitals that often say they can
14 do this cannot do it in the time
15 frame that we'll need them to do
16 it, especially if you start
17 prehospital cooling, where you do
18 not want that patient warming up
19 again. They don't have four hours
20 or six hours to ramp up.

21 Most of the hospitals, at
22 least in New York City, who do
23 this, it's in the ICU with a
24 designated ICU bed. We know those

1 patients don't often even get EDs,
2 you know, in a short period of
3 time. So it takes a commitment
4 from the hospital.

5 What we've discovered is you
6 send an ICU team down. We're
7 requiring really MOUs with the
8 hospital saying they will do that
9 in a realtime mechanism to maintain
10 the cooling, if the patient is
11 brought in.

12 Another issue is as these are
13 not State-designated specialty
14 referral centers, we're going to
15 require online medical control
16 permission to go. I don't know if
17 you have that same plan.

18 DR. MYERS: We don't have
19 the same -- we don't have the plan
20 to require online medical control
21 to do that. Again, in our area,
22 most of the patients who do survive
23 out of our hospital cardiac arrest
24 end up at one of those four

1 hospitals.

2 I'm going to work with the
3 flight service to see if they're
4 able to take one of the coolers on
5 the helicopters from an electrical
6 load and space standpoint. Because
7 they're doing a lot of these
8 transfers in. So I think we'll end
9 up having these patients end up at
10 one of those four hospitals,
11 anyway.

12 DR. KAUFMAN: That means
13 that these post event patients,
14 they're bypassing the closest
15 hospital, possibly.

16 DR. MYERS: Not
17 necessarily. No, not necessarily.

18 DR. KAUFMAN: That's an
19 issue we dealt with. One other
20 point is when you -- the STEMI, a
21 lot of these do need cap. We're
22 working on a separate designation
23 for STEMI hypothermia. So if they
24 either went into arrest after the

1 12-lead EKG with the STEMI, there
2 will be a separate designation for
3 those that could both do
4 hypothermia and interventional
5 catheterization.

6 And we've had a lot of
7 discussion at our REMAC on
8 whether -- you know, how that's
9 going to figure in.

10 One of the biggest challenges
11 we're having with this project and
12 others is requiring the hospitals
13 to give you the information after
14 you bring the patient in. They
15 won't do it voluntarily. We're
16 actually going to have agreements
17 signed saying they will provide the
18 designation, because you wouldn't
19 have any QA if you don't actually
20 have those agreements in place.

21 DR. MYERS: Fortunately,
22 with our main medical directors
23 that are part of our REMAC, they
24 have privileges at those four

1 hospitals and are able to access
2 records. I believe -- and correct
3 me if I'm wrong -- but Article 30
4 allows us to approach the hospitals
5 for QA and almost mandates that
6 they provide the REMACs the
7 information. So...

8 DR. MARSHALL: Dr. --
9 we'll go to Dailey and then Dr.
10 Broderick.

11 DR. DAILEY: Dr. Myers,
12 thank you. That was a great
13 presentation and provocative. The
14 question I had is just a point of
15 clarification on the algorithm,
16 which looks pretty firm. It's
17 already been published, it looks
18 like. Maybe I'm reading this
19 incorrectly. This is postcardiac
20 arrest. You mentioned traumatic
21 arrest or pregnant. It says yes,
22 follow the appropriate protocol.
23 Right on the top there.

24 DR. MYERS: You know

1 what? I apologize. Between the
2 monitor and transport, the advanced
3 airway protocol, there is an arrow
4 that should be not be there.

5 DR. DAILEY: Okay. That
6 makes sense.

7 DR. MYERS: I appreciate
8 your pointing that out.

9 DR. DAILEY: Okay.

10 DR. MYERS: So this
11 arrow --

12 DR. DAILEY: So there
13 would be a second -- after monitor
14 and transport, there's an asterisk,
15 then follow the advanced airway
16 protocol. That arrow goes away.

17 DR. MYERS: So this is
18 correct on here. I apologize for
19 the confusion on the handout, but
20 that arrow should not be there. So
21 if they're trauma arrest or
22 obviously pregnant, you go to the
23 appropriate protocol, monitor,
24 transport as with the appropriate

1 based protocol.

2 Thank you for pointing that
3 out.

4 DR. DAILEY: My pleasure.

5 DR. MARSHALL: Anything
6 else?

7 DR. DAILEY: Thank you.

8 DR. MARSHALL: Dr.
9 Dailey?

10 DR. DAILEY: Jeff, I
11 really appreciate this -- this
12 needs to be coming here. We need
13 to be discussing things like this
14 at this body, how to advance the
15 care for our patients in New York
16 State. You're doing it. Thank you
17 very much.

18 A couple of just brief
19 comments to the protocol, and a
20 couple to answer Dr. Kaufman's.
21 One of the salient cases that was
22 done that way that they talk about
23 a lot in their presentations was
24 actually a drowning patient, and

1 the other is that we would have to
2 go to the STAC, I think, before we
3 start talking about chilling trauma
4 arrest patients because of the
5 complications of hypothermia and
6 trauma.

7 So I think that you're being
8 appropriately conservative with
9 your protocol and inclusionary, as
10 would be best.

11 I would also suggest the
12 thought of bypass to a PTCA center,
13 PCI center, whatever you want to
14 call it today, just because so many
15 of these patients should get that.
16 This again should go back to the
17 Cardiac Advisory Committee because
18 they still have not changed the M
19 and M reporting requirements for
20 our cardiology partners who, if
21 they were to cath these patients,
22 who we know are the highest risk
23 patients, it would count against
24 their numbers.

1 And if there's a cardiologist
2 that's willing to take these
3 patients to the lab, as they
4 should, as the best chance for
5 these patients to have optimal
6 outcomes, it needs to not count
7 against their numbers.

8 DR. MYERS: That's right,
9 because even with the promising
10 numbers that have been presented
11 here, the mortality is still very
12 high, and that is definitely a
13 concern. We want to encourage our
14 cardiology colleagues to do that.

15 I'd almost wonder if the
16 cardiac advisory committee should,
17 as they're going through in their
18 standards for PCI centers, perhaps
19 include that this is a therapy that
20 must be part of the package as well
21 as, you know, adding to the change
22 in the M and M reporting, so that
23 it encourages the cardiologists to
24 cath these patients soon.

1 One impressive case from Iowa
2 when I visited out there, I saw a
3 video from a cath of a young male
4 who was in sudden cardiac arrest
5 who, on the fluoroscopy you could
6 see the thumper continuing to do
7 CPR. He had been cooled, and the
8 cardiologist was cathing and
9 opening his LAD. That patient
10 walked out neurologically intact,
11 you know, a guy in his 40s, you
12 know somebody that obviously has
13 many, many, many more years to
14 contribute to society, many more
15 years with a family, walked out.
16 Where if we don't encourage
17 ourselves and our colleagues to go
18 to the extra mile for some of these
19 patients, you know --

20 DR. DAILEY: And protect
21 them.

22 DR. MYERS: Yeah, and
23 protect them.

24 DR. DAILEY: A couple of

1 other things. First is out in
2 Pittsburgh one of the initial
3 interventions that they're making
4 in the emergency department is
5 cheap. You know, we talk about the
6 Intercool, we talk about the Arctic
7 Sun and all these other fancy,
8 expensive cooling processes,
9 actually you're not going to get
10 people down to temperature for a
11 good six hours or so. Two liters
12 of saline isn't going to chill
13 somebody, it's going to start
14 cooling.

15 But what they actually do in
16 the emergency department is just
17 put them on a cooling blanket, and
18 that's it. So cooling blankets are
19 already available in most of the
20 operating rooms, and they're cheap.
21 So it's not something where you'd
22 need to make a significant
23 infrastructure investment in the
24 emergency department.

1 In fact, some of the
2 hypothermia programs don't use any
3 of the fancy new technology, they
4 just use dedicated nursing care,
5 cooling blankets and ice packs.

6 Just the last brief comment
7 is on your diazepam dose. This is
8 just actually referring back to the
9 protocol. If you would consider
10 moving your bolus of diazepam to
11 after you check what the arterial
12 pressure is. There'd better not be
13 10 milligrams of diazepam going
14 into a patient with an arterial
15 pressure of --

16 DR. MYERS: That dose I
17 pulled off of a Pittsburgh
18 presentation. It's a very, very
19 good point. I'm not sure -- I
20 guess it's an issue of trying to
21 counteract. And I think the reason
22 that they do that before the
23 arterial pressure check is they want
24 to control the shivering. The

1 shivering is going to generate more
2 heat and negate your cooling,
3 whereas we can always add dopamine
4 to bring the pressure up and
5 maintain the blood pressure.

6 If it's okay with the body,
7 I'd like to keep it where it is,
8 with those considerations.

9 I also like your comment, and
10 actually Dr. Kaufman's comment
11 combined about online medical
12 control for -- I don't want to say
13 for diversion, but for destination
14 decision.

15 DR. KAUFMAN: Appropriate
16 destination decision.

17 DR. MYERS: Appropriate
18 destination decision. And if
19 that's something that the body
20 feels strongly about, we'll
21 definitely add that in, at least
22 until we have PCI centers with
23 hypothermia capability in as part
24 of our specialty center

1 designation.

2 DR. MARSHALL: Okay. Dr.
3 Broderick.

4 DR. BRODERICK: Yeah.
5 I'll echo Dr. Dailey. Good. I
6 made a note here, good. Good
7 because it is cheap, and I think
8 that's going to have some traction
9 with hospitals in regards to -- for
10 them to continue this, because I
11 think that would be a concern of
12 mine; that you would do great work
13 in the field, get to a hospital,
14 and then subsequently that patient
15 wasn't continued to be cooled. And
16 certainly losing the potential good
17 neurologic outcome that the work
18 already started in the field.

19 And it's really that simple
20 as I think that it starts the
21 process, it's cooling packs placed
22 in the axilla and the groin, and
23 just keeping a good eye on
24 shivering and keeping them down, I

1 think, is very helpful.

2 Another concern I have, are
3 you going to have access -- post,
4 obviously, doing this, but are you
5 going to have access to comparative
6 data preinitiation of this to be
7 able to compare it? Is that what
8 you're looking at, I assume?

9 DR. MYERS: From a
10 quality improvement effectiveness
11 standpoint, yes, and fortunately,
12 at least in the City of Buffalo the
13 primary transporting agency is
14 going to an electronic medical
15 record, which is going to help with
16 that chart pulling data collection
17 aspect.

18 And as I mentioned, as the
19 physicians that we have in our
20 REMAC, we've got physicians on
21 staff at each of those hospitals,
22 so we have access to the records.

23 DR. BRODERICK: I mean,
24 there's a lot of variables involved

1 in actually getting that, so that's
2 going to be tougher, but I would
3 certainly be interested in knowing
4 what the ED temperature is once
5 they arrive. The problem, of
6 course, being that you're not going
7 to actually start the cooling in
8 that period of time, so you're
9 going to have to -- I don't know if
10 you want to look at comparative
11 data before, if you have some
12 centers that started to cool and
13 maybe they get to that end point
14 sooner than before. There's a lot
15 of variables that I could see that
16 would make publishing this
17 challenging.

18 But certainly I think from a
19 QA standpoint trying to find
20 something that has some teeth in it
21 that's easily measurable that will
22 have so many variables involved, we
23 should try to latch onto, if we
24 can.

1 DR. MYERS: Thank you for
2 the suggestion.

3 DR. MARSHALL: Andrew had
4 a comment, and then Dr. Funk.

5 MR. JOHNSON: Yes, at the
6 bureau we've contacted North
7 Carolina EMS and Wayne County.
8 Their programs are going very well,
9 which is fairly mirrored to -- it's
10 gone so well that they've decided
11 to expand it into some of the
12 trauma patients. They have had one
13 drowning and one hanging reversal
14 through this new protocol of
15 theirs.

16 One of our concerns, as Ed
17 says, is the hospital end. Wayne
18 County has done a very aggressive
19 campaign with the hospitals.
20 Initially they only started
21 transporting to those hospitals
22 that would actually continue the
23 cooling. In fact, the paramedics
24 would stay at the hospital with the

1 ER physician to assist in the
2 treatment.

3 One problem they had is with
4 the tympanic temperatures. They're
5 considering going to the esophageal
6 probe. Is that anything you have
7 considered as of yet?

8 DR. MYERS: No, to answer
9 that question, no, we haven't
10 talked about going to a esophageal
11 probe. Sometimes it's hard enough
12 to get paramedics to do rectal
13 diazepam, just because of the
14 sensitive nature of that, so we
15 didn't think about going a little
16 more invasive with the temperature
17 monitoring.

18 Certainly if Wayne County
19 ends up going that way and they
20 show that it works, and we get our
21 guys comfortable with this
22 protocol, we can start branching
23 out into those types of things.
24 Certainly they're able to put down

1 NG tubes, patients intubated and it
2 helps, you know, placing the
3 esophageal problem and containing
4 that. I'm going to have to see
5 what the price is on that and take
6 it into consideration.

7 MR. JOHNSON: Well, what
8 about advanced airway protocol,
9 once they return to circulation
10 using a combi --

11 DR. MYERS: At the
12 present time, unless the medic is
13 credentialed for RSI, then it will
14 be, you know, usual intubation. So
15 again, hopefully the -- you know,
16 that patient and the patient who is
17 neurologically depressed enough,
18 we're talking about patients who
19 are neurologically depressed that
20 we're not going to be stimulating a
21 significant gag reflex, or that
22 type of thing.

23 A lot of these patients may
24 already be intubated by the time

1 they have a return of spontaneous
2 circulation.

3 Again, we wanted to keep it
4 simple and not add too much into
5 the armamentarium at the point
6 where, again, most of our
7 paramedics aren't doing RSI.

8 MR. JOHNSON: The last
9 question I have about the training.
10 Is this going to be uniform
11 training with all the agencies or
12 something you set up under your
13 REMAC?

14 DR. MYERS: We'll do kind
15 of a centralized training type
16 thing that we'll be able to go out
17 to the agencies and train the
18 trainer type setup. This way at
19 least we have some assuredness of
20 some consistency.

21 Our REMAC and the three
22 regions have started to do a little
23 bit more online type training as
24 well, so -- again, to maintain

1 consistency in our protocols and
2 some other aspects.

3 MR. JOHNSON: How many
4 agencies are you considering using
5 it first?

6 DR. MYERS: Right now we
7 have funding for 15 units, which
8 we're probably going to distribute
9 to rural metro and Buffalo, which I
10 have got it in there as their
11 assistant medical director, so that
12 makes that easy as well as the
13 other commercial provider that's up
14 in the city of Buffalo.

15 There are definitely other
16 larger volume services like Transam
17 and Allstar down to our south that,
18 if they're interested in
19 participating, we can distribute
20 the coolness appropriately. We're
21 not shooting for a cooler in every
22 ambulance. Obviously, in the city
23 of Buffalo we would not need to do
24 that. We're looking at putting it

1 more on our supervisor vehicles or
2 fly cars whereas, perhaps down in
3 Walt's territory you may need it on
4 several of the ambulances because
5 of how things are operating. But
6 we have got funding for 15 up front
7 so.

8 MR. JOHNSON: Wayne
9 County put it on their supervisors'
10 rigs and not the ambulances just
11 because of the jurisdiction and
12 other complications.

13 DR. MARSHALL: Dr. Funk,
14 and then Dr. Dailey.

15 DR. FUNK: Sure. In
16 regards to the destination
17 facility, I see there's an asterisk
18 on the transport.

19 DR. MYERS: Right.

20 DR. FUNK: Right now you
21 go to the closest hospital, but
22 what's the asterisk for?

23 DR. MYERS: The asterisk
24 is our REMAC's suggestion that it

1 would be appropriate to transport
2 lights and sirens with that
3 patient. That's something standard
4 throughout our protocol that long
5 before I came to western New York,
6 they decided that that would be
7 appropriate to suggest when it
8 would not be appropriate to
9 transport lights and sirens versus
10 appropriate to transport light and
11 sirens. And, trust me, there's not
12 a lot of asterisks in our protocol.

13 DR. FUNK: Is it
14 reasonable in your area -- because
15 you said not all of the hospitals
16 are intending to be able to cool --
17 is it reasonable in your area for
18 every one of these patients to go
19 to a cooling facility? Or is it
20 too distant?

21 DR. MYERS: In some cases
22 it may be too distant, but in those
23 situations there are fewer
24 hospitals, so it's a little bit

1 easier to work with them to get a
2 program up and running. I didn't
3 say that not everybody is
4 interested or willing to cool, it's
5 just that even if they end up at
6 one of the outlying facilities,
7 those patients tend to end up at
8 one of those four.

9 DR. FUNK: They're going
10 to be transferred.

11 DR. MYERS: They're going
12 to be transferred.

13 DR. FUNK: But there is
14 going to be a delay for the cooling
15 and the paramedic is not going to
16 stay with them.

17 DR. MYERS: No. That's
18 correct. That's correct. And
19 that's why as Dr. Kaufman said,
20 their experience in New York City,
21 we're going to need a do a bunch of
22 out reach as well for the hospital
23 so...

24 DR. FUNK: Because in New

1 York State we all know that a
2 paramedic can't continue to work on
3 a patient once they arrive to the
4 hospital.

5 DR. MYERS: Of course.
6 We wouldn't want to violate the
7 law.

8 DR. FUNK: So in regard
9 to those patient who are -- moving
10 right along -- who are distant from
11 the best, most appropriate
12 receiving center, one of -- there's
13 a protocol that they used in Maine
14 where patients who had returned
15 spontaneous circulation were put in
16 a helicopter and the helicopter
17 took them to a cooling center. I
18 don't know the details of how the
19 helicopter maintained the cooling.
20 They did. I'd be worried about
21 putting a big heavy cooler on an
22 aircraft. However --

23 UNIDENTIFIED VOICE: Put
24 the patient outside the plane.

1 DR. FUNK: That would
2 work. But I mean, if the cooler in
3 the ambulance has extra saline, you
4 could just hand that to the flight
5 crew, and they could probably keep
6 it cool, they just probably -- you
7 know, I'm just speaking from my own
8 helicopters. We can't put a cooler
9 on the aircraft for weight and
10 balance purposes.

11 But that's something to
12 think about. If you have a patient
13 that's way distant, this might be
14 an indication to use an aircraft to
15 get a patient to the intended
16 facility more quickly and maintain
17 that cooling.

18 DR. MYERS: We have had a
19 very small number of from the field
20 cardiac patients, which personally
21 I think that's a very appropriate
22 use of the helicopter.

23 DR. MARSHALL: Couple
24 more comments. Dr. Dailey? Then

1 you had a comment.

2 DR. DAILEY: This is a
3 topic that will generate a lot more
4 discussion. I'd like to make sure
5 we bring it right back to its
6 simplest components. We're talking
7 about giving somebody two liters of
8 saline, talking about just making
9 him cold. From that perspective I
10 think that this is very clearly
11 something that falls well within
12 the scope of our providers, we
13 should just say go ahead and do it.

14 Now, the other things that we
15 need to recognize as possibilities
16 are that very quickly we can get
17 carried away with the idea of the
18 fact that we're inducing
19 therapeutic hypothermia.

20 We're not. We're starting a
21 process that will hopefully be
22 carried through in a hospital that
23 will ultimately create hypothermia.
24 Two liters of saline makes them a

1 little chilly, maybe make them
2 shiver a little bit. We're not
3 going to do much more than that in
4 terms of getting them cold. And it
5 can be cheap. You've gotten a
6 grant to get some electronic
7 coolers on board your ambulances.
8 That's great. But the truth is
9 that you can take a couple of
10 liters of saline, you store it in a
11 fridge, put ice packs around them,
12 put them inside a regular Igloo
13 cooler you buy at Wal*Mart, Kmart
14 or whoever's mart for five bucks
15 and carry it around in your
16 ambulance for 12 to 24 hours and
17 keep it at temperature.

18 You know, that's been done
19 with other studies involving
20 products like blood to see whether
21 or not it works, and it does. So
22 we're not talking about great
23 financial ramifications for
24 services, and I think that's

1 important for us to remember. This
2 shouldn't be another one of these
3 unfunded mandates that we hand to
4 the services. Tympanic
5 thermometers are nice, but you know
6 something? You don't need really a
7 thermometer at all. That's
8 something, you know, we're choosing
9 to add in, but an esophageal probe
10 and a potential for a real
11 significant expense, not
12 necessarily part of what we're
13 talking about here.

14 Keeping it simple for our
15 perspective, letting the tail wag
16 the dog. Let's let EMS drive care
17 in the hospital. If we're chilling
18 them down and the hospitals are
19 choosing not to continue, what is
20 clearly established by ILCOR as a
21 standard, that's the hospitals
22 choice. Let's wag that dog. We're
23 doing it with wave form
24 capnography. We should be doing it

1 with this. Let's approve this
2 protocol and move on.

3 DR. MYERS: Just a
4 comment on the tympanic
5 thermometers. Actually, it is an
6 integral part to the protocol.
7 There's a lot of patients in the
8 experiences that have been
9 described are already cooled, to
10 begin with, and if they're already
11 at target, we don't want to add
12 more cold saline and drop them
13 below the target. That's a minor
14 expense.

15 DR. MARSHALL: It sounds
16 like pretty much everyone around
17 the table is in support of this, so
18 is there any -- I just have one
19 comment, and then if there's any
20 specific comments on the protocol,
21 you know, we'll go there and just
22 try to move it forward.

23 One of the things I think
24 Dr. Kaufman mentioned we've been

1 dealing with in New York City is
2 what happens when the patient goes
3 back into arrest after you've got
4 loss and are transporting the
5 patient? I mean, what do you do in
6 terms of the protocol? Are you
7 going to continue cooling and
8 continue to transport or stop
9 cooling?

10 DR. MYERS: We're going
11 to continue transport, we're going
12 to go back to whatever primary
13 protocol is there. And again, I
14 hope that I don't need the protocol
15 with paramedics. But they're going
16 to go back to -- whether it's a PEA
17 asystole v-fib, v-tach algorithm.
18 The saline's up there and running.
19 I'm not going to ask them to stop
20 doing CPR to change the bags out to
21 warm the saline.

22 So I'm all right. I think it
23 will be okay to leave that running,
24 you know, and then get to the

1 hospital.

2 DR. MARSHALL: Okay.

3 Dr. Henry, and then you have a
4 comment.

5 DR. HENRY: You're doing
6 this as a study? You intend to
7 collect data and publish this or
8 compare it to others?

9 DR. MYERS: We intend to
10 collect data for our quality
11 improvement program and obviously
12 to share with our colleagues around
13 the table here in the hopes that
14 this will be implemented across the
15 state.

16 DR. HENRY: I was
17 impressed with your survival
18 numbers. I said, holy mackerel,
19 this is amazing. But I see that
20 your inclusion is you have
21 spontaneous circulation for five
22 minutes. I was just looking at
23 wakes, and their other inclusion is
24 that you have an entitled CO2 of

1 greater than 20, then went to the
2 protocol. Well, that selects
3 people who have a better chance of
4 survival.

5 DR. MYERS: Correct.

6 DR. HENRY: It's not all
7 comers. So, in order to compare
8 results with other results, when
9 you have some variability, you
10 know, in the inclusion and in your
11 drugs, it would be good to follow
12 people, publish the results or at
13 least collect them.

14 DR. DAILEY: There's one
15 other potential --

16 DR. HENRY: In those
17 cases -- huh?

18 DR. DAILEY: I was going
19 to say there's one other potential
20 study that's going to be very
21 interesting. The numbers would be
22 small. Which would be look at the
23 15 units you put these coolers on.
24 Look at their results for ROSC over

1 the course of the last year
2 compared to any other comers in
3 your max catchment area. Then
4 follow the 15 units with 30 other
5 units throughout the region. And
6 let's see what sort of a Hawthorne
7 effect you have from just putting
8 that cooler on board the ambulance,
9 whether better CPR or better
10 resuscitations. And you know
11 something? If it does that, great.
12 That's working, too.

13 DR. MARSHALL: Any
14 comments on the protocol? All
15 right. I'll entertain a motion to
16 approve it or present it.

17 Dr. Dailey. Second?

18 Any further discussion?

19 MR. WRONSKI: Just when
20 this goes back to the SEMAC, I
21 would just ask that we articulate
22 what questions we wanted to bring,
23 what recommendations we wanted to
24 bring to the CAC. We can do that

1 for the next meeting.

2 DR. MARSHALL: All those
3 in favor, raise their hands.

4 Opposed.

5 Sustained. Motion carried
6 unanimously. Thank you.

7 Moving right along, New York
8 City rescue medic curriculum. Did
9 we get that?

10 MS. FULTS: I've reviewed
11 it and I think it looks pretty good
12 and -- but I do have two people in
13 training that are reviewing it.
14 We'll discuss it when we first get
15 into training, and if you guys are
16 still going, maybe I can run back
17 in here. If not, could we bring a
18 second motion to SEMAC if it's
19 approved?

20 DR. MARSHALL: I think
21 the discussion was that we wanted
22 to see the curriculum and make sure
23 the curriculum was going to be
24 appropriate because there were some

1 procedures that were going to be
2 done by rescue medics at the scene
3 under direct medical physician
4 control.

5 Dr. Kaufman?

6 DR. KAUFMAN: Actually, I
7 wasn't at the meeting when it was
8 presented, but from what I
9 understand, one of the major points
10 of discussion was placement of the
11 Foley catheter by the paramedics.

12 That was actually changed to
13 be a physician control option,
14 taking into account the discussions
15 here.

16 DR. MARSHALL: All the
17 protocols would be done with the
18 medical director on scene.

19 DR. KAUFMAN: Well, some
20 are standing orders and most of the
21 more advanced procedures are done
22 with an on scene.

23 MR. JOHNSON: Dr.
24 Gonzalez had removed some of the

1 things we had questions about at
2 the last meeting, made them
3 physician options at the scene, so
4 that really took away most of the
5 questions from our last meeting.

6 DR. MARSHALL: Any
7 objection to moving this forward
8 and then bringing it up this
9 afternoon if training and ed is
10 satisfied with the curriculum?

11 No objections?

12 All those in favor of moving
13 those forward, raise your hand.

14 Opposed?

15 Sustained. Motion carried.

16 Susquehanna, anybody here?

17 Anybody have any questions?

18 Anybody have any questions?

19 Yes.

20 MS. CHIUMENTO: I have
21 two things. On page 10 and 11
22 there was reference to EMT-Is doing
23 intubation. I'm not sure if the
24 drugs are in their curriculum, as

1 intubation as part of an EMT-I's
2 full practice.

3 DR. MARSHALL: Would you
4 like to answer that?

5 DR. MASARECH: Yeah.
6 Currently the EMT-Is are not
7 going -- there's no drug therapy.
8 I don't have numbered pages here.
9 Do you have a particular protocol?

10 MS. CHIUMENTO: I think
11 it was 19.

12 DR. FUNK: Oxygen
13 administration?

14 MS. CHIUMENTO: Yes, I
15 think it was oxygen administration.

16 DR. MASARECH: On mine,
17 at the intermediate level it just
18 talks about ET for airway control,
19 intubate up to three times, nothing
20 about drug therapy.

21 MS. CHIUMENTO: I'm
22 sorry. CC. Critical care, down at
23 the bottom. I wrote IC. It's CC.
24 Down at the medical control option.

1 DR. MASARECH: Okay.

2 MS. CHIUMENTO: Again, I
3 don't know if those drugs are in
4 the critical care curriculum or
5 not. Are they?

6 DR. MASARECH: I believe
7 we've had some techs that have been
8 trained for that level, definitely
9 not intermediate.

10 MS. CHIUMENTO: On page
11 17 under anaphylaxis, there was --
12 you still have subQ Epi in there.
13 I know American Heart Association
14 is not recommending subQ Epi for
15 anaphylaxis. It's still in for
16 allergic reaction, but not for
17 circulation.

18 And then also on here was
19 paramedic epi for cardiovascular
20 collapse, IV or subcutaneous/IV.
21 I'm not sure, again, for
22 cardiovascular collapse, whether --

23 DR. MASARECH: Right.
24 That subQ -- I think we have a

1 newer version of that. We looked
2 at that. That was taken out. That
3 should be IV.

4 MS. CHIUMENTO: Okay.

5 DR. DAILEY: Sorry,
6 Sharon, if I may, your anaphylaxis
7 session, again, Sharon picked up
8 that should be IM, not subQ.
9 Reading it that way, it appears
10 that you're asking to give 1 to
11 10,000 epi subQ or IM. I don't
12 think that's --

13 DR. MASARECH: I've got 1
14 to 1,000 on mine.

15 DR. DAILEY: Up above it
16 has, but it says 1 to 1,000 down
17 below, under paramedic, for
18 cardiovascular collapse epi, 1 to
19 10,000 IV -- IV dose .3 subQ.

20 DR. MASARECH: That was
21 taken out. That's out. There's no
22 more subQ for that. It just should
23 read the IV second dose.

24 MS. CHIUMENTO: Page 20.

1 Page 20, which is the obstructed
2 airway, there's no mention here of
3 doing any field measures at all and
4 I wondered, I mean, in some of the
5 other protocols you refer to a
6 specific field protocol. This one
7 there's no mention there at all.
8 It's just for completeness. I'm
9 sure that you're doing those things
10 exactly --

11 DR. MASARECH: We had a
12 reason on that. We try to keep our
13 protocols strictly to ALS but every
14 once in a while for some protocols
15 the BLS comes. We make the
16 assumption they all know they're
17 BLS and try not to repeat it.
18 That's why it's not there.

19 MS. CHIUMENTO: Okay.
20 Because my main concern here was
21 the CPR patient, so that would be
22 the issue there.

23 Page 23, you have BLS
24 administering albuterol to heart

1 failure and pulmonary edema and I
2 believe that the State protocol
3 only has it for asthma.

4 DR. MASARECH: That may
5 have been an oversight. They were
6 lumped together.

7 MS. CHIUMENTO: Under the
8 general guidelines.

9 DR. MASARECH: But again,
10 the BLS people won't -- they
11 shouldn't even be reading these
12 protocols.

13 MS. CHIUMENTO: But we
14 didn't --

15 DR. MASARECH: Ours is
16 separate.

17 MS. CHIUMENTO: Page 25,
18 I think you've got your breech
19 presentation. I wonder if it might
20 be worthwhile adding a reference to
21 driving an air passageway for a
22 patient in the breech presentation
23 during the delivery, and using
24 fingers and just kind of expanding

1 the cervix -- cervical opening in
2 case the patient takes a breath.

3 That may be in your training
4 and so it may not necessarily be
5 here but since you already have
6 something there --

7 DR. MASARECH: And again,
8 I think, yeah, that's one of those
9 BLS versus ALS deals that doesn't
10 show up. Okay.

11 MS. CHIUMENTO: Page 35
12 it says that you've got dopamine
13 being administered to a patient and
14 it says IO is preferred. Would
15 that even be a conscious patient,
16 because it makes it look like --

17 DR. MASARECH: What
18 protocol is that?

19 MS. CHIUMENTO: Page 35.
20 To then finally get medical
21 control, it says that IO is
22 preferred, it says IO is preferred.
23 Would that also be unconscious
24 patients?

1 DR. MASARECH: That's a
2 pediatric protocol?

3 MS. CHIUMENTO: No, it's
4 an adult protocol.

5 DR. MASARECH: We'll take
6 a look at that. Obviously, we're
7 not -- we're doing more IOs than we
8 had previously. That may be
9 something that slipped right
10 through on there. I can't find
11 that protocol.

12 MS. CHIUMENTO: Page 40.

13 DR. MARSHALL: Can we --
14 I'm sorry, Sharon, but can we try
15 to concentrate on the changes as
16 opposed to the ones we've approved
17 already? I know that IO -- it
18 looks from the document that IO was
19 already in there. I mean, I think
20 it's great to look at it, but --

21 DR. FUNK: It seems like
22 the terminology "IO preferred" is a
23 little different.

24 DR. MARSHALL: No, I

1 understand that. But today we're
2 looking at the changes that they've
3 brought forward.

4 DR. MASARECH: We've been
5 using this protocol for a year.

6 MS. CHIUMENTO: Page 39.
7 I'm assuming the yellow things are
8 -- the things that are yellow,
9 highlighted in yellow? You've got
10 -- you've just got an incomplete
11 line there. I think it probably
12 just needs to be taken out.

13 Under critical care paramedic
14 stable, you've got --

15 DR. MASARECH: Which
16 protocol is that?

17 MS. CHIUMENTO: Wide
18 complex. Down below, in the notes,
19 the options, there's a full line,
20 but on the upper part stable, it
21 just -- there's a --

22 DR. MASARECH: Right.

23 MS. CHIUMENTO: I don't
24 think most of them are related to

1 the actual changes, so he can
2 incorporate them in.

3 DR. MARSHALL: That would
4 be great.

5 Page 40 under bradycardia,
6 for high degree block, atropine
7 first but no repeat. Do you want
8 to -- is there a repeat available
9 or is it just up to a maximum of 3
10 milligrams?

11 MR. JOHNSON: Did you
12 want to use atropine on high degree
13 blocks as well?

14 DR. MASARECH: I'm seeing
15 just under bradycardia, you're just
16 saying there's just not a warning
17 about using it under high degree
18 blocks. Is that right?

19 MR. JOHNSON: Yeah. I
20 mean, the way it is there, you can
21 use it on all blocks, also.

22 DR. MASARECH: We can put
23 a warning in there that says, you
24 know --

1 MR. JOHNSON: Basic
2 first.

3 DR. MASARECH: Right.

4 MR. JOHNSON: And we did
5 have questions about the RMA
6 protocol on page 57, refusal.

7 DR. MASARECH: Okay.

8 MR. JOHNSON: Really it
9 is much different than the current
10 State BLS protocol. We were
11 wondering why the difference is.

12 DR. MASARECH: That
13 protocol actually is an unchanged
14 protocol that's been in use in our
15 region for probably ten years. It
16 was actually put through the legal
17 side of United Health Services
18 Hospitals in Binghamton. They're
19 the ones who generated our refusal
20 form and we've had really good
21 success with that.

22 We actually print up a
23 separate form, three copies. It's
24 given to the patient at the time of

1 signoff. It was felt years ago
2 back when we were still doing
3 paper, that simply signing the back
4 of the PCR was insufficient.

5 MR. JOHNSON: I don't
6 think I have issue with the form
7 itself, it's just the criteria on
8 page 56. They're all highlighted
9 in yellow.

10 DR. MASARECH: I don't
11 think I have that. I don't have
12 any of our special protocols here.

13 MR. JOHNSON: Doesn't
14 appear to be changed since the last
15 protocol. Very much different than
16 the statewide BLS protocol that was
17 given out a couple of years ago.

18 DR. MASARECH: We can
19 take a look at that. Like I say,
20 we haven't had any issues with
21 refusal. Is ours more restrictive
22 than the BLS?

23 MR. JOHNSON: No, BLS is
24 much more restrictive.

1 DR. MASARECH: Okay.
2 Most of our medics are complaining
3 we're restricting them. We're
4 careful.

5 MR. JOHNSON: It's a
6 conflict with the statewide
7 protocol. So you have to make a
8 decision if you're going to use the
9 BLS one from the State or a totally
10 different one like this.

11 DR. MASARECH: Okay.

12 MR. WRONSKI: I have a
13 question about the interfacility
14 transport protocol.

15 DR. MASARECH: Yes.

16 MR. WRONSKI: Critical
17 care paramedics with appropriate
18 training. You mentioned Heparin,
19 but there's no mention of
20 nitroglycerine, and nitro and
21 Heparin are probably -- that's the
22 most common combination that we
23 transport.

24 DR. MASARECH: The only

1 reason that was thrown in there was
2 we wanted to make sure the agencies
3 in the region bring their
4 interfacility transport protocols
5 back to the REMAC for an approval
6 of what they're doing, so we get an
7 idea what they're doing.

8 But we have tons of people
9 that transport with nitro, and
10 they're required to have their own
11 training module and keep their own
12 file up.

13 That wasn't meant to be an
14 exclusive list. It's just an
15 example, basically.

16 MR. WRONSKI: Okay.

17 MR. JOHNSON: Under that
18 protocol, are you allowing the CCs
19 and paramedics to administer
20 antibiotics?

21 DR. MASARECH: Not with
22 the first dose.

23 MR. JOHNSON: But they
24 will be giving antibiotics during

1 transport?

2 DR. MASARECH: They would
3 continue a drip that's already
4 started. I mean, our transports
5 are not that long. It's not like
6 somebody will say at 11 clock
7 you're going to start, you know,
8 Rocephin for the next gram or
9 something, no. They would just be
10 monitoring what's already running.

11 MR. JOHNSON: Have these
12 medications been included in the
13 curriculum for CCs?

14 DR. MASARECH: It's
15 included in their training by their
16 agency, if they want to do the
17 transport protocols.

18 MR. JOHNSON: Is that
19 approved by the region?

20 DR. MASARECH: Those are
21 only regionally approved programs,
22 correct.

23 MR. JOHNSON: The
24 training is approved.

1 DR. MASARECH: The whole
2 document has to be approved, right.

3 MS. CHIUMENTO: I just
4 have one other question. It's on
5 neonatal resuscitation. For
6 meconium aspiration, you have
7 continue proper suctioning until
8 airway clears. Down below that you
9 have intubating and attaching
10 meconium aspirator and suctioning
11 in that way. And you might just
12 want to add the proviso that's only
13 done in patients in respiratory
14 distress. The American Heart
15 Association is no longer
16 recommending we do it carte blanche
17 any longer.

18 DR. MASARECH: Okay.
19 Yes.

20 DR. OLSSON: There's
21 several mentions of capnography,
22 and there's a comment. One of the
23 requirements that we put in was
24 recordable. There are various

1 capnographies who can be -- that
2 can be interpreted as wave form
3 that is not recordable, and our
4 feeling was that there needed to be
5 some documentation at the end,
6 because things do change, and that
7 would be the only thing that the
8 provider would have to say, "When I
9 put it in, this is what it was."
10 So that was a backup that we put in
11 in ours, and it's a comment only.

12 DR. MASARECH: Okay. So
13 we can just draw that -- I mean, we
14 obviously wanted to be in line with
15 the state recommendation on
16 capnography. So, I mean, that's
17 just a word change, like you say.

18 DR. MARSHALL: Any other
19 comments? About the protocols?

20 DR. DELAGI: Just a
21 question about the EMT-I use of
22 cardiac monitoring. I think that's
23 a scope issue. Is that a scope
24 issue? And then in the protocols

1 it makes reference to monitoring
2 EKG, but there were obviously no
3 treatment options for dysrhythmia.
4 I would be concerned about that.

5 DR. MASARECH: The EMT-I
6 should be able to identify the four
7 lethal, you know, rhythms, and
8 they've been monitoring for years.
9 I mean, I'm not sure, they have no
10 drugs or anything, but...

11 MR. JOHNSON: That's
12 outside the scope of practice. We
13 have not been taught that from '98.

14 DR. MASARECH: You've not
15 been taught monitoring any longer?

16 MR. JOHNSON: No
17 monitoring, no rhythm checks,
18 aren't able to appreciate the four
19 rhythms. Are they using monitors
20 or ADs?

21 DR. MASARECH: Most of
22 the time they're using monitors.
23 They're an intermediate -- our only
24 intermediates in our region -- I'm

1 sure we haven't had any new ones,
2 probably since -- I've been doing
3 it since '97. I don't think we've
4 had an intermediate class. So most
5 of our intermediates are old and,
6 you know, and have been doing it
7 for a long time.

8 So I'm not aware of anybody
9 new that's coming down the pike
10 that's getting, you know, rhythm
11 recognition. So that can probably
12 be taken out for the number of Is
13 that we have in our region. Not
14 that many. I don't think
15 anybody -- nobody has too many
16 intermediates, anymore, I would
17 think.

18 DR. MARSHALL: Here's
19 what I have so far. Clarification
20 on skills on the EMT-I level
21 dosage. Clarification on
22 administration IO. Informed
23 consent. We'll look at that.
24 Interfacility transports, there

1 were some clarifications on the
2 approval, regional approval of the
3 transport protocol.

4 DR. MASARECH: That's
5 what we just --

6 DR. MARSHALL: And
7 neonatal meconium aspiration.

8 Anything else on the
9 protocols? All those in favor of
10 approving the protocols with these
11 recommendations, raise your hands?
12 Thank you.

13 Opposed?

14 Sustained. Thank you.

15 Motion carries.

16 Thank you very much.

17 Dr. Kaufman.

18 DR. KAUFMAN: Just for
19 clarification -- I don't know if
20 it's a good time to do it -- on the
21 documentation requirements for
22 capnography as per the State, there
23 was a little bit of discussion.
24 Will the State have specific

1 requirements for that
2 documentation?

3 DR. MARSHALL: The
4 discussion was that you should have
5 something from the capnography
6 machine that gives you something to
7 document.

8 DR. KAUFMAN: Is that a
9 requirement?

10 DR. MARSHALL: The motion
11 was --

12 MR. JOHNSON: It had to
13 be recordable by paper or
14 downloadable at the hospital.

15 DR. OLSSON: It's a
16 requirement that we put in in
17 central New York.

18 DR. KAUFMAN: No, no, but
19 for the State. I mean, it's not
20 sufficient they document on the
21 PTR.

22 MR. JOHNSON: It has to
23 be recordable somehow.

24 DR. MARSHALL: We'll come

1 back to that in a few minutes at
2 the end. Just in case anybody was
3 wondering if we were going to get
4 out of here without discussing
5 capnography.

6 Westchester protocols.

7 DR. HAYDOCK: Dr. Cordi
8 is here.

9 DR. MARSHALL: Dr. Cordi.
10 Okay. Westchester. That's
11 the hot seat down there.

12 Can you guys just say your
13 name so we can make sure we
14 attribute comments to the right
15 guilty party?

16 DR. HAYDOCK: Haydock.
17 Tim Haydock, H-A-Y-D-O-C-K.

18 MS. O'CONNOR: Katherine
19 O'Connor. K-A-T-H-E-R-I-N-E, O
20 apostrophe C-O-N-N-O-R?

21 DR. CORDI: Dr. Cordi,
22 C-O-R-D-I.

23 MR. RAYMOND CORDI: I'm
24 Raymond Cordi, C-O-R-D-I.

1 DR. MARSHALL: Anybody
2 have any questions, comments?
3 Protocols? Karen?

4 MS. CHIUMENTO: 3.0, you
5 have a dose of 5 milliliters of Epi
6 for proof. American Heart
7 Association's recommendation is 3
8 milliliters.

9 DR. CORDI: Pediatric.

10 MS. CHIUMENTO: Pediatric
11 3.0. Okay.

12 And in 5.0 --

13 DR. CORDI: I'm sorry.
14 Wait a second.

15 DR. HAYDOCK: You can
16 change that to three.

17 MS. CHIUMENTO: 5.0,
18 pediatric also, in both number 1A
19 and also on 5.1, number 5, both of
20 those places, you want to just
21 change it to either every two
22 minutes or ten cycles and pediatric
23 is ten cycles instead of five
24 cycles because you're doing 15 to 2

1 instead of 30 to 2.

2 Also, one of the things that
3 we've done with some of the other
4 regions is American Heart
5 Association doesn't have any
6 recommendations for pediatric post
7 resuscitation receiving EP doses of
8 their antiarrhythmic.

9 So what we've done with the
10 other regions is just made that a
11 medical control option.

12 This is in 5.1.

13 DR. HAYDOCK: What page
14 are you on?

15 MS. CHIUMENTO:
16 Pediatric, 5.1. Down in number C
17 and G in medical control options.

18 DR. HAYDOCK: Okay. Got
19 that.

20 MS. CHIUMENTO: 9.0,
21 American Pediatrics, also, they
22 recommend 5 to 10 cc bolus instead
23 of the 20 cc bolus and give cardio
24 debit shock.

1 Then I just had a question
2 about 10.0 that's, under pediatric,
3 and that is I couldn't find
4 anything about intranasal naloxone
5 in neonates, so I didn't know
6 whether that was a supplemental
7 treatment or not because of the
8 small size of their nares. There's
9 an issue with ET dosing of naloxone
10 because of the poor absorption.
11 I'm not sure whether or not they
12 would also affect intranasal in the
13 neonate as well.

14 DR. CORDI: We can -- I
15 mean, we vetted -- we --

16 MS. CHIUMENTO: That's
17 fine. I just couldn't find it
18 anyplace so I brought it up for
19 that reason.

20 And then the only one on the
21 adults is 4.6.

22 DR. CORDI: 4.6?

23 MS. CHIUMENTO: Uh-huh.
24 4.6D under the notes. It's got

1 asynchronous cardioversion or
2 hypertension, unconsciousness,
3 pulmonary edema, as well as for
4 technical reasons. I couldn't find
5 anything in the American Heart
6 Association guidelines except for
7 if you couldn't synch or if the
8 patient was in poly -- unstable
9 polymarked VT. Those are the only
10 two places I could find for
11 asynchronous.

12 Because you've got if any
13 patient has hypotension -- it looks
14 from this note as though any
15 patient with hypotension,
16 unconsciousness or pulmonary edema,
17 you would go to asynchronous
18 instead of synchronous. So I think
19 it may be just be a typo.

20 DR. HAYDOCK: We'll
21 clarify that.

22 MS. CHIUMENTO: Thank
23 you. That's all.

24 DR. MARSHALL: Are there

1 more? No. There were some other
2 -- there were some not
3 disagreements or conflicts, but
4 differences between your protocols
5 and what the American Heart and
6 SEMAC approved before. Sharon
7 mentioned some of them. Also the
8 use of lidocaine in 4.6. Use of
9 term regular versus irregular in
10 4.5 where you use A fluoride fibs,
11 MAT. 4.7, amiodarone or
12 procainamide, I think American
13 Heart only amiodarone is
14 recommended. 5.1, cardiac arrest,
15 shockable, ET drug routes. Most
16 people are removing them because
17 it's not recommended anymore.

18 DR. HAYDOCK: It's a good
19 drug. I'm surprised.

20 DR. MARSHALL: Which one?

21 DR. HAYDOCK:
22 Procainamide. Works well, but it's
23 -- so you want that out.

24 DR. MARSHALL: Go ahead.

1 MR. WRONSKI: Well, if I
2 could jump in, when the SEMAC, you
3 know, brings to your attention that
4 a prior vote with the American
5 Heart is recommended, we've adopted
6 American Heart. It doesn't mean
7 that a region can't modify, but if
8 you choose to modify, you have to
9 give us a reason why you would
10 ignore this, you know, the American
11 Heart recommendation and stay with
12 something.

13 So it's not like you
14 absolutely have to go with the
15 American Heart, but you have to
16 give a rationale as to why you
17 would do this.

18 So would that be -- the chair
19 is comfortable with that.

20 DR. MARSHALL: So you
21 like it.

22 DR. HAYDOCK: Well, I
23 think it's a useful and good drug
24 for some of these dysrhythmias, and

1 some of the units still carry it
2 and -- they all do. And we feel
3 that it is useful. And so that was
4 our rationale.

5 I think a lot of people are
6 still using it in the ERs, and it's
7 fairly easy to use. So that was
8 our rationale.

9 DR. MARSHALL: All right.
10 I don't have any problem. Anybody
11 else have any comments about that
12 or anything else in their
13 protocols?

14 DR. HAYDOCK: But we're
15 not using Vertilium.

16 DR. BRODERICK: The only
17 question I would have is you say
18 some of the units are carrying it.

19 DR. HAYDOCK: No, all of
20 them are.

21 DR. CORDI: It is on our
22 mandated medication list currently.
23 Not Vertilium.

24 DR. MARSHALL: Any other

1 comments?

2 So, the only thing I really
3 wrote down was intranasal Narcan
4 for neonates. I don't know if
5 anybody has any experience with
6 anything with that. No?

7 DR. KUGLER: I have a
8 question, but I'm just --

9 DR. MARSHALL: Yes?

10 DR. KUGLER: Again, this
11 is kind of confusing. So we're
12 saying that if they're carrying it,
13 then it's okay to use it? I mean,
14 without having literature to
15 support it, I think you asked for
16 rationale as to why they're going
17 to deviate from the State standard.
18 I don't know that I heard a
19 rationale other than they're
20 carrying it.

21 Now, if we're going to use
22 they're carrying it as a reason, as
23 a rationale to go against the State
24 standard, I think we're going to

1 set a precedent we don't want to
2 set. So I just haven't heard
3 anything that is better than that
4 as a rationale.

5 DR. HENRY: He said it's
6 a good drug.

7 DR. KUGLER: That's a
8 rationale certainly. They're
9 carrying it and it's good because
10 they say so.

11 DR. HENRY: It's been
12 used for a long time. People use
13 it. I mean, it's one of the --

14 DR. KUGLER: I'm not so
15 concerned about the procainamide as
16 the precedent to use something that
17 we're carrying and we say is good.
18 I mean, if the State's adopted
19 something, we've adopted it for a
20 reason. And I'm not suggesting
21 that procaine is bad, I'm just
22 suggesting we need to make a
23 linkage here that's more than it's
24 good and we're carrying it as a

1 precedent for the SEMAC.

2 DR. DAILEY: Dr. Kugler
3 makes a really good point here. We
4 have very clearly said the AHA
5 recommendations are ours. We've
6 also vacillated as far as we can on
7 the idea of what a protocol that
8 comes from this committee is going
9 to mean and how much we will
10 recommend and how much we will
11 suggest and how much we will accept
12 variability between the regions.

13 We also have no data from the
14 State as to what drugs are being
15 used and how often and what the
16 results of those drugs are. If
17 there's going to be variability, we
18 should be better able to track our
19 outcomes, but unfortunately all we
20 record are BLS interventions for
21 our patients. We have no record
22 whatsoever of the ALS interventions
23 our patients receive.

24 Based on that, the only

1 literature we really have to go by
2 is what the heart association has
3 chosen, in which case what we
4 should do is follow Dr. Kugler's
5 recommendation here and say no.
6 Procan, whether or not your docs
7 like it, is not something that the
8 State has said is a good idea.
9 We're following the recommendations
10 of the heart association.
11 Procainamide is no longer one of
12 them.

13 DR. BRODERICK: Yeah, I
14 really think this should be a
15 regional thing. I understand what
16 you're saying, Dr. Dailey. For our
17 region, took off procainamide only
18 to keep it simple, and I think
19 that's the main thing that we
20 stress in our region for our EMTs,
21 is that you only have -- and
22 especially when it comes to drugs,
23 it's our regional thought process
24 that the more toys you have in your

1 bag, the less you do really good
2 basic care that we really want to
3 stress.

4 However, I personally
5 wouldn't want to take away from my
6 region's ability if, in fact -- the
7 question is, the devil's in the
8 details. How much detail? To say
9 that procainamide has no use in
10 certain dysrhythmias I think is
11 inaccurate. It clearly does. It's
12 a function of using it
13 appropriately.

14 And I would say to their
15 discretion, if they feel that their
16 EMTs are sufficiently trained and,
17 you know, it remains at least an
18 option that they could use it
19 because there is literature that
20 supports its use.

21 But I would stress to most of
22 the regions that to keep it simple
23 and to keep your drug bag as
24 limited as possible I think in our

1 experience has significant value
2 due to the reasons cited. The more
3 toys you have to play with, the
4 more you will, and the less you'll
5 do the real basic things that in
6 our opinion in our region really
7 saves lives in the field.

8 DR. MARSHALL: I can tell
9 you there are at least four regions
10 in the State that actually have
11 procainamide in their protocols, so
12 it is there. People are --

13 MR. JOHNSON: Stopping in
14 all the regions.

15 DR. MARSHALL: No. I
16 don't know if everybody took it
17 out. There's significant
18 variability in what people are
19 carrying.

20 DR. KUGLER: I think my
21 comment wasn't -- again, wasn't to
22 suggest that procainamide was a bad
23 drug.

24 DR. MARSHALL: No.

1 DR. KUGLER: And I think
2 in this case it's an or statement
3 that you have in the protocols
4 whether to use amiodarone or
5 procaine in a stable V-tach
6 situation and your medics are
7 comfortable with the drug. We're
8 not talking about the comfort level
9 and the variability within regions,
10 which I think should be respected
11 at the SEMAC.

12 I think what we're discussing
13 here is Mr. Wronski asked for a
14 rationale why procainamide, why
15 we're deviating from what we've
16 already accepted, and I just think
17 a comment from whatever region's
18 going to present something that's
19 deviating from something we've
20 already accepted is, we need to
21 have a rationale other than we're
22 comfortable with it and we have it.
23 I think that's a precedent that we
24 have to be very careful with. As

1 we all get comfortable with things,
2 and we have them, they may not be
3 good. In this case I'm not arguing
4 procainamide is bad. It may be
5 good and it has shown efficacy in
6 many dysrhythmias.

7 I just think as a
8 precedent -- so what I think I'm
9 hearing is that the rationale is
10 that procainamide has demonstrated
11 benefits to our patients with
12 dysrhythmia. That kind of language
13 I think needs to be included as
14 opposed to, well, we have it, for
15 the record, we have it and we like
16 it.

17 DR. DAILEY: I think the
18 thing that goes with that, though,
19 Josh, that we should look to is to
20 make sure we get enough data from
21 Westchester that if it's benefiting
22 the patients in Westchester County,
23 I can only dream that it would
24 probably benefit the patients in

1 Albany County as well, and I would
2 want the benefit of their
3 experience.

4 DR. KUGLER: And that I
5 think would be great, if all of us
6 can provide that sort of
7 statistical information, that
8 quality information. I think
9 that's great. In this case I think
10 we're talking about just accepting
11 something that's a little off what
12 the State has already accepted.
13 And just a comment or an asterisk
14 with a rationale. That's all I'm
15 saying.

16 This is not directed towards
17 Westchester. This is for all of us
18 when we come on board. If it's
19 Suffolk County, and we say, well,
20 we have got it in our bag and we've
21 had it in our bag, so now we're
22 using it. I think it's dangerous
23 precedent.

24 DR. HENRY: My sense of

1 this is we make some
2 recommendations about conditions
3 that should be covered in
4 protocols, make some
5 recommendations on drugs. We
6 adopted the AHA stuff in one
7 recommendation. We've always said
8 if people have something that's not
9 in there, we want to hear from them
10 why, if they have something
11 additional, we want to hear from
12 them why. Because we know what we
13 put out is incomplete. Otherwise,
14 we wouldn't be cooling heads some
15 places. We're not doing that all
16 over. We're cooling bodies. Or
17 something like this.

18 AHA makes recommendations on
19 drugs like amiodarone, but years
20 later, look at the studies. It's
21 30 percent effective. That's all.
22 70 percent of the patients don't
23 get converted, and in one of the
24 algorithms you have Y complex in

1 unstable patients tachycardia.
2 Procainamide is an alternative
3 drug. So that's in the algorithms
4 now. So that's a perfectly useful
5 drug if someone doesn't convert
6 with another drug to have as an
7 option. That makes sense to me.
8 It's glib to say it was good, but
9 the drug has been around for a long
10 time. Newer ones come. I wouldn't
11 be surprised five years from now
12 we'll react Vertilium.

13 DR. HAYDOCK: I never
14 said we should.

15 DR. HENRY: So I take
16 what you say. But if they're using
17 it for certain things that are
18 established for what other
19 medications we have are not a
20 hundred percent effective, that's
21 the rationale.

22 DR. HAYDOCK: I mean, I
23 do hear the argument and as one
24 who's always been in favor of

1 having the State protocol for
2 across all the regions, I certainly
3 understand the point. And if this
4 body felt very strongly about this,
5 I would defer to that, the region
6 would clearly defer to that. We
7 would also make it a medical
8 control option, if that makes you
9 feel more comfortable.

10 DR. MARSHALL: A year and
11 a half ago, every region submitted
12 a letter they were going to at
13 least meet the minimum requirements
14 of the American Heart Association
15 guidelines. I think that that's
16 probably where the baseline should
17 be. And Dr. Kugler is right, maybe
18 we shouldn't just use something
19 because it's there, but in some of
20 the protocols from Westchester
21 that -- one is endotracheal
22 medications, and I think that that
23 -- most people have just gotten rid
24 of that altogether.

1 DR. CORDI: That
2 shouldn't be -- those records, if
3 they're in there, it's a typo.

4 DR. MARSHALL: It's in
5 there. Yeah. So that --

6 DR. CORDI: Do you know
7 what particular protocol because
8 we'll remove it.

9 DR. MARSHALL: So, I
10 mean, if that's just a typo, it's
11 not an issue.

12 DR. KUGLER: They're in
13 some of the notes. When you look
14 through some of the notes, you'll
15 see them.

16 DR. CORDI: Then that's
17 -- yeah, that's a typo.

18 DR. MARSHALL:
19 Dr. Broderick.

20 DR. BRODERICK:
21 Dr. Haydock put it on the table
22 that -- I do like that -- as a
23 medical control option. What it
24 will do is for the EMTs that may

1 move throughout the regions
2 maintain some consistency. And, of
3 course, there's got to be medical
4 control options. That's going to
5 be the most variable part of the
6 protocol that we see from region to
7 region, based on physician
8 preference and a variety of
9 circumstances that may exist within
10 that region, mostly being, frankly,
11 physician preference.

12 So I certainly would
13 encourage that movement of procaine
14 to that portion.

15 DR. DAILEY: I agree with
16 Dr. Broderick's comment on that.
17 Medical control option, in the keep
18 it simple idea.

19 DR. BRODERICK: Thank
20 you.

21 DR. MARSHALL: Any other
22 comments? We have some typos.
23 Neonatal nasal Narcan. Turn
24 anything around? Neonate?

1 And then procainamide as
2 well. Is there anything else?

3 Seeing nothing else, all
4 those in favor approving with those
5 recommendations?

6 Opposed?

7 Sustained. Thank you.

8 Any comments? Do you guys
9 have any other comments?

10 Dr. Kaufman, New York City.

11 Dr. Kaufman, New York City.

12 You can stay where you are.
13 You don't have to move over there.

14 DR. KAUFMAN: New York
15 City just has one protocol
16 submitted for review, and really
17 just one line within a previous
18 protocol, but I thought it was
19 worth a couple minutes of
20 explanation, so I actually have
21 these slides -- these are not my
22 slides. They're actually made by
23 Dr. Soloff at the New York State
24 Department of Health. I thought

1 that it would be useful to show a
2 few of them.

3 New York City has been
4 working on a burn disaster response
5 plan, and the possibility that
6 there's a major burn disaster with
7 75 or more patients, you know,
8 receiving severe burns, we thought
9 about what would our plans be for
10 using the burn beds within the city
11 which would obviously be
12 insufficient even with what they
13 are capable of expanding to, to
14 would still be severely
15 insufficient.

16 So the New York State
17 Department of Health has been
18 working with the REMAC and the fire
19 department and other agencies to
20 develop a burn disaster response
21 plan, and I'll just show you
22 briefly a few slides within their
23 plan.

24 So the purpose is

1 insufficient burn surge capacity
2 locally and nationally, and this
3 plan is to enhance both New York
4 City and also New York State health
5 care institutions respond to a burn
6 disaster.

7 Slide. They established
8 these virtual burn consultation
9 centers. Currently there's a plan
10 for two of them, one in Rochester
11 and one at Cornell Medical Center
12 in New York. Actually the VBCC
13 that would coordinate would be the
14 one where the burn is not. So then
15 if there's a major burn disaster in
16 New York City, the Rochester VBCC
17 would do the coordinating.

18 You can go to the next slide.
19 There are four different tiers of
20 burn hospitals for this burn
21 disaster plan.

22 Tier 1 New York City
23 hospitals are our four current burn
24 centers.

1 Tier 1 regional burn disaster
2 hospitals would be those in the
3 other abutting counties.

4 Tier 2 New York City burn
5 hospitals are the 17 trauma centers
6 which have received additional
7 supplies to handle burns.

8 Tier 3 would be the nonburn,
9 nontrauma centers.

10 Then Tier 4 would be all the
11 remaining hospitals in New York
12 City.

13 So bed availability will be
14 coordinated centrally by -- in the
15 case of the event in New York City
16 by VBCC in Rochester.

17 Next slide. Actually, if you
18 go to the next slide. Just going
19 through the process of how they
20 come up with this plan.

21 The next slide. So the --
22 all of the participating hospitals
23 within New York City have received
24 burn cart supplies, including these

1 items.

2 This is -- you can go to the
3 next one. This is the picture of
4 the burn cart, showing where the
5 supplies are. They have all be
6 prepositioned in all these
7 hospitals.

8 Next slide. This is kind of
9 the crux of the plan. So the idea
10 is to get those patients who are
11 most appropriately treated for
12 their burns at those hospitals most
13 appropriate to treat them.

14 Realizing that if there's a burn
15 and burn patients are brought to
16 our major burn centers, patient
17 with minor burns, they may be
18 occupying beds when someone with
19 more severe burns would be better
20 utilized. So we would want to
21 transport that patient to a
22 secondary burn center to bring in a
23 more critical patient and to
24 coordinate that at this virtual

1 burn coordinating center.

2 This is kind of the grid that
3 shows, depending on the age of the
4 patient and percentage of body
5 burned, which tier of hospital that
6 patient would eventually be
7 directed to, not necessarily from
8 the scene, possibly from the scene
9 possibly in a secondary transport
10 after they have been stabilized.

11 Next slide. This again just
12 shows how the virtual burn
13 coordination center gets notified
14 and how the process is coordinated.
15 Won't go into the details.

16 Next slide. Next slide.
17 Again, you can't see this, but this
18 again discusses some of the
19 components of how these patients
20 are either primarily or secondarily
21 transported to the appropriate burn
22 disaster receiving hospital.

23 And that's the long story for
24 this protocol change, which adds

1 one line into our major burn
2 transportation procedure that says
3 the event is declared a burn MCI by
4 EMS, New York City OEM, New York
5 State Department of Health, or New
6 York City DOHMH, in which case
7 patients may be transported to New
8 York City burn disaster receiving
9 hospitals as per this New York City
10 burn disaster plan.

11 I think that's the change to
12 the protocol, and that's the reason
13 for it.

14 DR. MARSHALL: Dr. Funk?

15 DR. FUNK: I saw one
16 slide where it talks about
17 out-of-state hospitals. For care
18 as specialized as burn care, there
19 are burn centers that we utilize on
20 a regular basis out of New York
21 State.

22 Would it be appropriate to
23 incorporate those into the burn
24 disaster plan?

1 DR. KAUFMAN: Yeah. I
2 think there are some in New Jersey.

3 DR. FUNK: Right. But
4 there's burn centers in
5 Massachusetts, Pennsylvania, and
6 all those are appropriate for New
7 York State patients, right?

8 DR. KAUFMAN: Right.

9 DR. FUNK: And they're
10 incorporated.

11 DR. KAUFMAN: I don't
12 think they are currently, but this
13 is all part of a working plan.
14 Right now the coordination has
15 really been within New York City,
16 and hopefully eventually statewide,
17 so that if the events happen up
18 here, we can coordinate all of our
19 burn beds in this kind of way.

20 DR. MARSHALL: I think
21 for the out-of-state hospitals, the
22 discussion was that would be
23 coordinated through their burn
24 coordinating center in the event of

1 an incident. So that whether
2 Massachusetts -- you know, as far
3 away as Virginia, perhaps, if we
4 really needed to, that that would
5 be coordinated through that.

6 DR. VAN ROEKENS: So, again,
7 both of the virtual burn centers,
8 the coordination of those are fully
9 aware of what the out-of-state
10 hospital's capacity is and have
11 that as part of standard protocol
12 for either upstate burn or, you
13 know, a city emergency?

14 DR. KAUFMAN: This plan
15 hasn't gone into place yet, so --
16 but I would think that that would
17 be part of their plan.

18 DR. VAN ROEKENS: I agree
19 with Dr. Funk.

20 DR. FUNK: Well, the
21 regular burn centers we use in
22 northern New York are not any of
23 the ones you talk about so --

24 DR. KAUFMAN: Right.

1 DR. VAN ROEKENS: Despite
2 this being a New York State
3 meeting.

4 DR. KAUFMAN: Right. As
5 far as the plan presented to us,
6 it's really the New York City
7 component of the plan, which allows
8 us to utilize a nonburn hospital as
9 well as to -- and that coordination
10 we really wanted to occur someplace
11 not within the city, if that's
12 affected. So to receive the data,
13 to coordinate all of these patients
14 as well as the transport in
15 accordance with these plans within
16 New York City and probably
17 Westchester and Nassau County
18 currently. I don't think plans
19 beyond that have really moved
20 forward much.

21 DR. VAN ROEKENS: But the
22 speed in which that could be done
23 is pretty critical, as New England
24 events, Rhode Island, etc., have

1 shown us.

2 DR. KAUFMAN: Right.

3 MS. CHIUMENTO: Just
4 knowing that from Upstate New York
5 you need to know the burn centers
6 are coordinated very well between
7 Buffalo and -- I expect that each
8 of - either one of the burn centers
9 would probably have contacted all
10 the other burn centers in the
11 nation, and would be able to -- you
12 know, they would just need to
13 coordinate.

14 I mean, rather than the local
15 area trying to figure out where to
16 send this burn around the country,
17 that they could just serve as the
18 triage, basically, and say, all
19 right, we've got this many beds.
20 Our beds are full. We need to send
21 these patients to Connecticut. We
22 need to send these patients to
23 Massachusetts.

24 DR. VAN ROEKENS: Agreed.

1 As long as that's part of their
2 standard operating protocol. Any
3 of the virtual burn centers, I just
4 would request that they consider
5 the area.

6 DR. KAUFMAN: I think the
7 key to any plan like this, though,
8 is everybody will know what they
9 have, especially during one of
10 these disasters but it's having
11 somewhere, anywhere, someone have
12 all the information to know, well,
13 there's somebody sicker and that
14 patient can go there.

15 And unless there's a plan in
16 place for that kind of information
17 exchange, it will never happen in
18 any real time just with hospitals
19 communicating amongst themselves.

20 DR. MARSHALL: Yes, Dr.
21 Delagi.

22 DR. DELAGI: Dr. Kaplan,
23 are you ready to roll this out to
24 the regional resource centers yet?

1 Have they been charged with dealing
2 with medical surge and burn surge
3 specifically? At least in the
4 downstate area.

5 DR. KAPLAN: The regional
6 resource centers?

7 DR. DELAGI: The regional
8 resource centers, yeah. They're
9 working on hospital surge and burn
10 surge right now, but --

11 MR. WRONSKI: There are
12 two components to this in the
13 state. There is the hospital
14 disaster preparedness unit that
15 works with the regional resource
16 centers in a burn plan, and there
17 is the New York City plan. All of
18 that is expected when it's, you
19 know, finally completed to be
20 coordinated as one whole.

21 I can't speak to all the
22 details of that, but I know that
23 the same people who are involved
24 with the state plan for the burns

1 are the same people who work with
2 the regional resource centers. So
3 they'll be included in all that,
4 but exactly how, you know, as we go
5 along, you know, I can't answer
6 that.

7 If you'd like, at some point
8 I can bring a representative from
9 the hospital disaster preparedness
10 unit to come in and talk as well.

11 DR. DELAGI: Just so
12 they're not duplicating.

13 MR. WRONSKI: They all
14 know about each other's efforts.
15 It's really the same unit. I mean,
16 there is a New York City separate
17 plan, but that's being coordinated
18 and information shared with the
19 State Health Department. So
20 everybody knows what everybody is
21 doing here. Exactly what the
22 final, you know, plan we'll look at
23 is still a work in progress.

24 DR. DELAGI: Thank you.

1 DR. MARSHALL: Any
2 questions for Dr. Kaufman?

3 All those in favor of
4 approving the protocol change for
5 burn disasters? We're talking
6 about major numbers of patients,
7 not 10.

8 Opposed?

9 Sustained. Motion carried.

10 That's it for protocols.

11 Two quick topics. I
12 shouldn't say quick. And it might
13 be.

14 There was some discussion
15 last year about online medical
16 control and whether or not it had
17 to be provided by an actual M.D.,
18 D.O. person sitting there with the
19 phone in their hand or the radio in
20 their hand versus using an
21 appropriately trained paramedic who
22 was speaking to someone in the
23 field with -- under the direction
24 of a physician.

1 The language in the
2 regulation that was actually in the
3 definition section, which actually
4 says that prehospital or online
5 medical control is advice and
6 direction provided an by an M.D. or
7 under the direction of an M.D. So
8 there's an option there, and I
9 think that we had had some
10 discussion of that in the past,
11 because there was a region or maybe
12 more than one region that was
13 utilizing paramedics or wanted to
14 utilize paramedics in the answering
15 center to give prehospital medical
16 direction.

17 And so I bring that back with
18 that language from the regulation
19 and ask for your comments.

20 Mr. Wronski.

21 MR. WRONSKI: And just to
22 clarify, it's actually the statute,
23 that's the statutory definition of
24 medical control. So it does

1 provide that sentence, which breaks
2 it out. It says provided by doctor
3 or under the direction of a doctor.

4 There is no regulation in
5 place currently that further
6 defines that as to what that might
7 mean. There is our policy that is
8 out which is somewhat in conflict
9 with that, and the questions come
10 up, because there are different
11 systems in the state where the
12 person who a paramedic or critical
13 care tech may be talking to at
14 medical control may not be directly
15 the physician. But those are
16 systems overseen by a physician and
17 there should be a physician
18 available.

19 So that -- but this question
20 has come up, and that's why it's
21 back on the table to discuss, to
22 get your advice and recommendations
23 on this. But I think the
24 statute's, you know, pretty clear.

1 It has, you know, under the -- read
2 that. I'm sorry.

3 DR. MARSHALL: Under the
4 direction of.

5 MR. WRONSKI: Right.
6 So -- and it's "or under the
7 direction of." So it wouldn't be
8 in there if they didn't expect
9 there to be two options.

10 DR. MARSHALL: I guess
11 one of the things or something we
12 can look at is we can look at what
13 "under the direction of a
14 physician" means. Does it mean the
15 physician has to be present in the
16 room, in the building, available by
17 cell phone 24/7? You know, I mean
18 what does under the direction of a
19 physician mean? At telemetry in
20 Maspeth, you know, you have a
21 physician sitting right there, but
22 if they've got five ALS calls
23 backed up, is it okay for the
24 paramedic or paramedic supervisor

1 to go through the protocols with
2 the crew on the phone? And same
3 thing in other areas.

4 Those are some of the other
5 things we don't have to decide
6 right now, maybe. Do we want to a
7 smaller group to put together some
8 options? That's just something we
9 can think about.

10 Dr. Van Roekens.

11 DR. VAN ROEKENS: In our
12 region, again, we use PAs and MPs
13 under the direction, direct
14 supervision of a physician, and I
15 think that if you place the
16 restriction that it just be a
17 physician, some of the single
18 coverage physician PA or physician
19 MP coverage EDs will have some
20 challenges meeting the demand of
21 the medical control. All these new
22 levels are already credentialed
23 through a process similar to the
24 physicians, and I think that that

1 generally serves the region well.

2 DR. MARSHALL:

3 Dr. Broderick.

4 DR. BRODERICK: To
5 illustrate that, I'll second that,
6 and even to further that, in our
7 region and under New York State law
8 there -- a volume of 15,000, you
9 can adapt with PAs and EDs with
10 direct medical backup. That direct
11 medical backup sometimes is but not
12 always an emergency physician. So
13 what we do is we have very
14 experienced PAs that actually are
15 out in the field frequently and
16 also teach our -- many of our
17 critical care paramedics in many
18 ways and receive those patients
19 directly from those EMTs; that some
20 -- certainly some of the backup
21 sometimes is an internist.

22 So I would say, providing --
23 having the internist now start to
24 talk to a paramedic when they have

1 no idea of the protocols, and every
2 on line medical control M.D. or PA
3 would need to go through the base
4 station, you know, understand our
5 protocols, read them and have an
6 online test.

7 So we do try to control it in
8 that manner. But that statutory
9 language is absolutely necessary in
10 our region for us to provide any
11 online medical control, unless a
12 larger place, you know, an hour
13 away want to provide all the
14 medical control. But I think
15 that's harmful to the patient.

16 I think the person who's
17 taking that call and subsequently
18 will take that patient is best
19 informed about that patient's
20 condition and how well they're
21 going to do. And it's a nice
22 handoff as well, once you take that
23 medical control call and
24 subsequently take care of the

1 patient after that.

2 DR. MARSHALL:

3 Dr. Kaufman, do you have a comment?

4 DR. KAUFMAN: I wasn't
5 clear on what you're saying as far
6 as -- because it sounds like there
7 are other people taking these
8 calls. But they're running the
9 case past the physician before
10 making those decisions?

11 Because in my mind, hearing
12 that language, it means there's a
13 physician directly involved online,
14 even if they're not on the phone.
15 But they're at least involved in
16 that case. It's not where there's
17 a PA or MP who's running the call,
18 giving the orders, and the
19 physician finds out about this the
20 next day.

21 That would be pretty
22 concerning to me, even though it
23 sounds like in your region that's
24 more the case. I would -- that's

1 easy for me to say because we don't
2 have this, but I would be strongly
3 against that. I think, you know,
4 we write protocols so all of what
5 they do is under a physician's
6 offline medical control. The
7 reason we have physicians,
8 hopefully certified online medical
9 control physicians who handle those
10 calls is because they have
11 familiarity with the protocols.

12 And so it shouldn't be an
13 internist who has no familiarity.
14 They should be calling a physician
15 who is an EMS physician, has been
16 trained in their protocols and
17 understands the issues on the
18 street.

19 MR. WRONSKI: If I could
20 comment just from an understanding
21 of the State system, I agree with
22 Dr. Kaufman the best thing to do is
23 have a physician on the other end
24 of the phone. There's no argument

1 there. That's always the best.
2 But that's not going to happen in
3 this state.

4 I'm putting that out to you,
5 if you say that it has to be
6 directly a physician, there will be
7 areas of the state which will not
8 have medical control.

9 What I think this body needs
10 to think about is what has, in
11 fact, been in existence -- these
12 systems exist like this, they've
13 grown up like this -- that to my
14 belief, and again, there's no
15 defining regulation. So what does
16 it mean "or under the direction of
17 a physician"? The body, the State
18 council has never decided to write
19 a defining regulation which says
20 what that means.

21 You could do that. You could
22 make a defining regulation. But
23 lacking that, you take what the
24 statute has, which is simple, and

1 this body and the State EMS
2 Council, if they choose to, could
3 provide some criteria of what they
4 hope is happening when a physician
5 isn't directly giving that advice.
6 What does "under the direction"
7 mean? In the room? Does it mean
8 that there's a physician who's
9 reviewing all of this that is
10 trained in online? I don't know,
11 but I think this body needs to
12 comment on that.

13 But from the State Director's
14 position, I'm advising you that
15 should you make the decision, all
16 right, that a physician must be
17 directly involved in each case,
18 that there will be areas of the
19 state where that probably will not
20 be possible today.

21 DR. MARSHALL: What I'd
22 like to do is maybe -- and I'll get
23 to the comments -- Dr. Broderick
24 and Dr. Kaufman and myself and

1 maybe a couple of other volunteers
2 could get together and maybe put
3 together a little outline of
4 possibilities that we could bring
5 back to the committee for more of a
6 discussion point to get off where we
7 want to have some kind of advice or
8 what have you.

9 DR. HAYDOCK: Yeah, I
10 happen to -- I do agree with
11 Dr. Kaufman. I think we have to
12 look at this extremely carefully
13 and I think your approach is a good
14 one, but I think it's a very
15 slippery slope. Medical control,
16 and typically are cases where
17 they're very complex cases with
18 perhaps difficult decision making,
19 that I'm not convinced in some
20 instances a PA or nurse
21 practitioner really has the skills
22 to do. Maybe in some cases they
23 would have the skills to answer
24 some questions.

1 But I think we need to be
2 very, very careful. It's a very
3 slippery slope, and they are
4 operating under our licenses, and
5 we need to keep that in mind.

6 DR. MARSHALL: A comment
7 down here, and then Dr. Dailey.

8 DR. COOLEY: Very
9 quickly, Craig Cooley from the
10 western region. We are actually
11 battling with this right now
12 because of a facility that we had
13 that was doing PA medical control,
14 and it was brought to the REMAC
15 because the standard has been
16 traditionally it has to be an M.D.

17 And the REMAC is honestly
18 divided. I think that there is the
19 practical reality that the rural
20 areas of this region for the
21 minimum levels that need to be
22 seriously looked at, but my biggest
23 concern is, the way this was
24 brought up today, was the comment

1 of having paramedics provide the
2 online medical control. And as a
3 former paramedic, you know, be a
4 little confused why my
5 quote/unquote equal is telling me
6 how to do things that theoretically
7 I'm calling for more advanced
8 control over.

9 So although it is a
10 concerning slope that we can go
11 down, I think there does have to be
12 some serious discussion about an
13 absolute we're not going below
14 this. And I think the midlevel
15 discussions probably are going to
16 be very long and complicated. But
17 I would have a hard time justifying
18 below that level providing, because
19 as it was already commented, these
20 are theoretically complicated cases
21 that have gone beyond the
22 protocols, and the only reason
23 they're calling is because they
24 want higher training.

1 DR. MARSHALL: Yes.

2 MR. ZEEK: As a provider,
3 I think my presumption about the
4 regulation or the statute is that
5 there is some realtime connection,
6 direction there with a physician,
7 no matter who's on the radio. So I
8 think that's what we've got to work
9 on.

10 MS. CHIUMENTO: Isn't
11 that one of the issues with being
12 certified versus licensure? We
13 have to function directly under a
14 physician. We cannot, you know,
15 take orders from other levels. The
16 issue a couple years ago back there
17 was poison control. We used to be
18 able to call poison control for
19 orders, and then they said, no, we
20 could not because they were not
21 staffed by physicians, at least not
22 online.

23 The same -- you know, it's
24 part of the same issue, I think.

1 DR. MARSHALL: I think
2 everybody has their own ideas of
3 what under the direction of a
4 physician might mean. I mean,
5 Dr. Kaufman has his idea, you know,
6 whether or not, you know, you have
7 a doctor sitting there on one line
8 and the paramedic sitting here on
9 another line. You know, and the
10 doc and the paramedic are talking.

11 Or if you have a PA and no
12 doctor in the room or the building,
13 I mean, you know, so those are some
14 of the things that need to be
15 fleshed out a little better.

16 Dr. Dailey?

17 DR. DAILEY: I think
18 there are so many different
19 considerations here that this
20 should just be tabled to a
21 subcommittee to discuss it.

22 DR. MARSHALL: Okay.
23 Anybody else would like to
24 volunteer? Dr. Kaufman and myself.

1 Okay. We have people there. Come
2 up to me after the meeting so I can
3 write everybody's name down.

4 Update on wave form
5 capnography.

6 VOICE: Looks like we're
7 out of time. (Laughter.)

8 DR. MARSHALL: First of
9 all, I think just to recap -- and
10 please, if I'm not correct, please
11 correct me if I'm wrong -- but
12 medical standards did strongly in
13 some very strong language put
14 forward the wave form capnography
15 as a standard of care for patients
16 who require intubation. And as
17 such, we put forward an advisory,
18 or we recommended that SEMAC put
19 out an advisory with those
20 recommendations with a date certain
21 for implementation for New York
22 State.

23 Those guidelines or that
24 advisory was given to the

1 Department and it went to their
2 counsel, and then is now in the
3 office of the commissioner.

4 One of the things that --
5 I'll let Ed speak a little more
6 about it -- is that as an advisory
7 it does not have the weight of
8 regulation or it does not have the
9 weight of an advisory that has been
10 approved by the council, SEMSCO.
11 And therefore -- and Ed, you can
12 finish up.

13 We cannot mandate the use of
14 wave form capnography in the
15 prehospital setting, and we can
16 sent the standard of care, and
17 that's what it is if we say that's
18 the standard of care. We cannot
19 mandate services to go out and
20 purchase the equipment and utilize
21 the equipment to provide wave form
22 capnography.

23 And, Ed, I will turn it over
24 to you.

1 MR. WRONSKI: It's a
2 little complex. Let me go back to
3 the statute first. The statute
4 fills in the ability of the SEMAC
5 to issue advisory guidelines in any
6 areas that it writes protocols in:
7 Treatment, triage and
8 transportation.

9 Typically an advisory is
10 something that discusses an aspect
11 of medicine, explains it and is
12 supportive typically of an existing
13 protocol or practice. And it helps
14 establish the standard of care.
15 And my discussions with the
16 division of legal affairs made it
17 very clear that an advisory helps
18 establish standard of care.

19 However, they did say that to
20 have -- to mandate something, you
21 really need to have a rule or
22 regulation or -- and another term
23 for this would be -- a protocol,
24 because protocols do have the

1 weight of the statute behind them.
2 So protocols are required to be
3 followed. You don't have a waiver
4 on that. So you write a protocol
5 and you have to follow it.

6 But mandating a particular
7 piece of equipment etc. is
8 something that you need to get
9 approved through the state council
10 and have it put in place as a rule
11 or a reg.

12 Again, the advisory has a lot
13 of weight. It helps establish a
14 standard of care. And so that if
15 you have a service who were to not
16 follow that advisory and
17 recommendations in that advisory
18 for the use of wave form
19 capnography to confirm placement of
20 the tube and continuous placement,
21 and they have a problem, the tube
22 gets misplaced, and there's a
23 complaint, and we confirm that they
24 have -- they had a misplaced tube

1 that they didn't find, one of the
2 things that would be put on the
3 table in any hearing would be, why
4 didn't you follow the SEMAC's
5 recommendation, the state medical
6 body who said that this is the way,
7 the best way to confirm ET
8 placement, tube placement, and that
9 is the standard of care established
10 by this body?

11 They have to come back with a
12 counterargument as to why they
13 didn't do that, and what they had
14 to confirm the tube placement, etc.

15 I'll give you an example in
16 medicine that I thought about as I
17 had conversation with counsel on
18 this, and that is the Brain Trauma
19 Foundation's brain trauma
20 guidelines, which are put together
21 by an international body of
22 neurosurgeons, have been
23 recommended and signed off on by
24 more than one commissioner of

1 health as the standard of care for
2 serious traumatic brain injury.

3 Yet in this state and in many
4 other states the guidelines are not
5 followed a hundred percent of the
6 time. There are, you know,
7 modifications to that.

8 Neurosurgeons make -- you know,
9 licensed neurosurgeons obviously
10 make the decision that we're going
11 to do something different or they
12 don't choose to follow that path.
13 But that is the standard of care.
14 And I'm quite sure that in
15 malpractice cases, it's brought up,
16 you know, why didn't you follow
17 this? And they make an argument as
18 to why they might have deviated
19 from that.

20 But again, we're not talking
21 about licensed practitioners, we're
22 talking about certified, who follow
23 our protocols and follow the rules
24 and regs.

1 But what counsel has told me,
2 in an advisory we can't put a
3 mandate in. We can issue it, give
4 an implementation date, all right,
5 but not mandate it. But it does
6 establish a standard of care.

7 At present the modified SEMAC
8 advisory -- modified in the sense
9 the counsel recommended a couple of
10 word changes from a legal
11 perspective, it does not change the
12 content or substance of the
13 advisory. And that's been sent now
14 to the commissioner's office and I
15 expect an answer from the
16 commissioner on this soon.

17 I will tell you, given this
18 late date, that I have recommended
19 that the actual implementation date
20 be pushed back a little bit,
21 although we issue the advisory as
22 soon as the commissioner approves
23 it, send it out, tell people this
24 is the standard that you've

1 recommended in New York State.

2 But again, we can't actually
3 mandate all services purchase this
4 equipment but we can advise them
5 this is what we believe is the
6 standard.

7 Yes?

8 DR. DELAGI: The question
9 really becomes, then, since REMACs
10 function as an extension of the
11 SEMAC, and since the DLA does offer
12 some immunity from liability and
13 coverage for REMACs, would you
14 agree that the DLA's opinion
15 extends to REMACs, too, in the
16 context that they should not be
17 able to mandate it either, but
18 rather include it as a standard of
19 care in a region?

20 MR. WRONSKI: It's
21 definitely a standard of care that
22 a REMAC can establish. Can a REMAC
23 mandate something, a piece of
24 equipment? I believe what -- you'd

1 have to follow the trail back to
2 the state standard, and whether or
3 not this is consistent with the
4 state standard.

5 And so if a REMAC currently
6 is saying, you know, we're saying
7 all of you need to do this, it
8 would be as a standard of care,
9 not -- I don't believe the REMAC
10 would have more authority than a
11 SEMAC.

12 What I'm going to suggest,
13 too, is so you'll have the
14 opportunity to ask direct
15 questions, I'll see if I can get a
16 lawyer to come here at the next
17 meeting to discuss this issue,
18 because it has ramifications as we
19 go along. But very clearly, when
20 you write an advisory, it is
21 establishing a standard of care.
22 People who decide not to follow the
23 standard of care are at risk.
24 They're at risk for not doing that,

1 and they have to have a good
2 rationale why they wouldn't do
3 this.

4 MR. BISHOP: To piggyback
5 on Bob's comment, our region before
6 the SEMAC made this a protocol. It
7 states in the protocol essentially
8 thou shall not intubate if you
9 can't do capnography. And if you
10 don't have capnography, you will
11 not intubate. That is our
12 protocol. That has been approved.
13 It has been approved by this body.
14 We have a date by which every
15 agency had to comply. Actually, I
16 don't think I don't believe that
17 date has dome yet. It comes at the
18 end of this month.

19 Are you saying that our
20 region is out of bounds by doing
21 that, or by using a protocol as
22 opposed to advisory we're allowed
23 to do that?

24 MR. WRONSKI: I believe

1 the answer would be since you put
2 it into a national -- regional
3 protocol, and that came up through
4 the state process and got approved,
5 that that probably is a mandate.

6 But it is a question that
7 we'll clarify. I believe it is,
8 yes.

9 MR. BISHOP: And
10 similarly, years ago we did that
11 with 12-lead EKG; that it was
12 standard of care and a protocol in
13 our region that if you have a
14 patient with chest pains, you have
15 to do 12-lead EKG. And we did it
16 with BGs, and so on. And these are
17 equipment that we require our
18 providers to use on our patients.

19 DR. HENRY: My view on
20 this, listening to Ed, is that it
21 not a mandate that an ambulance be
22 put out of service if it doesn't
23 have wave form capnography, but
24 what we did say is use a bag valve

1 mask or another way to ventilate a
2 patient, because what we're
3 recommending is for the
4 risk/benefit of intubation, if you
5 want to use that procedure, you
6 have to know that it's still in the
7 right place that you intended it to
8 be, given the hazards of movement,
9 our environment.

10 So it's a medical protocol,
11 but it doesn't -- it's not a
12 mandate that you go out and buy a
13 piece of equipment in order to
14 remain caring for patients in the
15 911 system.

16 So I think the protocol is
17 appropriate. If you want to
18 intubate, you have this safety
19 check as part of the process of
20 intubation and ventilation. And,
21 you know, the fact that they use an
22 advisory, I guess some of us think
23 that it's good for us to opine on
24 print. We could have done a

1 protocol route or other routes,
2 too, if we wanted to. And I think
3 part of this is the technicality of
4 what does an advisory mean.

5 MR. WRONSKI: Remember,
6 the difference is that the state
7 council has to approve protocols,
8 right? And so it approves the
9 state protocol, and that gives it
10 an additional weight. And in
11 hearings, we take state protocol
12 and apply it as we apply
13 regulations.

14 And if there's a variation
15 from that protocol, the ALJ looks
16 at that, there has to be a very
17 good medical reason that's
18 supportable to do that. But it is
19 rare that we've actually had a
20 state protocol -- you know, we
21 don't charge unless it's a
22 significant variation. But we've
23 introduced those. And again, we
24 use them similar to how we use and

1 enforce them in medical cases. But
2 again, you know, this is something
3 that I think the body needs to
4 think about some of the specifics
5 or nuances of what it means to
6 mandate something. And I think
7 we'll still need to discuss a
8 little bit more. And I'll try to
9 get counsel here next time. You
10 can ask him some specific
11 questions.

12 But at present, you know, it
13 establishes the standard of care,
14 and that's a significant statement.

15 DR. MARSHALL: Anybody
16 else on this side of the table?
17 Marie?

18 MS. DIGLIO: From what I
19 remember, Article 30 gives the
20 authority to approve ALS services
21 in the region to the REMAC. So
22 it's part of the REMAC's
23 requirement to operate as an ALS
24 service is that you have

1 capnography. A service can choose
2 not to be ALS. Doesn't REMAC have
3 that authority?

4 MR. WRONSKI: The REMACs
5 do write ALS protocols, and ALS
6 services have to follow those
7 protocols. You know, they can give
8 modifications, depending, but it
9 would -- you know, on first blush,
10 I'd have to say yeah. If you -- if
11 you say you want to practice ALS in
12 our area, you have to have the
13 following in place. I think that's
14 reasonable.

15 The only way it would not be
16 is, remember, anyone can appeal if
17 they believe that what you put in
18 place is unreasonable. Then it
19 would come to this body, and this
20 body would have to discuss that.
21 So don't appeal capnography,
22 please.

23 Then it would go to the
24 commissioner, potentially even an

1 Article 78. But I think the answer
2 to your question is, yeah, you
3 could. You could say this is what
4 an ALS service in our area has to
5 do.

6 DR. MARSHALL: This side.
7 Dr. Dailey.

8 DR. DAILEY: It's really
9 been entertaining to watch the
10 process. I believe I made the
11 original motion requiring wave form
12 capnography almost two years ago at
13 this point. It was passed
14 unanimously the first time. It's
15 been stalled at process, at the
16 council, it's been stalled at the
17 commissioner's office, and I don't
18 think in any way that mitigates the
19 risk to a service's choosing not to
20 use it.

21 All of our transcripts from
22 here are very clearly part of the
23 public record and every single one
24 of these transcripts would be

1 brought at a civil hearing should a
2 bad outcome occur to one of the
3 patients being cared for by a
4 service not reaching that standard.

5 If a physician is a medical
6 director for a service out there
7 that has not recommended wave form
8 capnography to their services,
9 they're not doing any favors to
10 that service they're providing
11 medical direction for.

12 I think it's time for us just
13 to stop playing semantic games
14 here. If what we need to do is
15 issue an advisory, issue the
16 advisory, but don't put a date on
17 it. Just issue the advisory at
18 this point, because the dates that
19 we've suggested have passed or are
20 about to pass. Just issue the
21 advisory that it's the right thing
22 to do.

23 And for this body, we should
24 never pass a protocol that doesn't

1 have a required equipment list for
2 ALS services, including 12-lead
3 electrocardiograms and wave form
4 capnography. It's been -- and
5 that's where we stopped. If we're
6 in this semantic game, let's just
7 use the tools at our disposal.
8 Protocols need to pass through
9 here. That's not in the protocol;
10 it's not required equipment for
11 ALS. Don't pass the protocol.

12 DR. FUNK: Hear, hear.

13 MR. WRONSKI: When the
14 English teacher speaks, even the
15 lawyers are quiet.

16 Most of the lawyers have BAs
17 in English to start with, so -- but
18 I agree with Dr. Dailey. The
19 body's made it very clear for a
20 couple of years that this is what
21 they feel is the standard. The
22 lawyers confirm that putting an
23 advisory establishes it as the
24 standard of care. This is what we

1 want you to do. What they have
2 said, though, is that you simply
3 can't in an advisory under the
4 statutory language mandate
5 something. But you can, simply by
6 establishing a standard of care,
7 kind of quasi mandate it, because
8 you'd have to make a heck of an
9 argument why you wouldn't be doing
10 this.

11 But I'll put it back on the
12 table as I did last time when we
13 had a big discussion then, is we've
14 much longer than capnography said
15 that defibrillation is the standard
16 of care in BLS, that everybody
17 should have an AED. And we found
18 out that in some cases some
19 ambulances don't ride with an AED
20 on them.

21 And so my recommendation
22 there -- by the way, I'm going to
23 recommend this to the state council
24 -- is that they agree to a simple

1 change -- this is for the AED
2 now -- in the equipment regulations
3 for ambulances, and simply add, you
4 know, an AED must be carried as any
5 other piece of equipment on every
6 ambulance, if you strongly feel
7 that's required. And I think it
8 is. I don't think -- you have a
9 state BLS protocol in every single
10 protocol that's been written by a
11 region includes the ability to
12 defibrillate. So I don't know how
13 you can argue that you shouldn't
14 have an AED on an ambulance.

15 So my recommendation is going
16 to be that we write that simple
17 addition to the equipment list.
18 The reason I say that is from my
19 prosecutorial purpose and from an
20 inspection purpose, the primary
21 tool that state has at its
22 disposal, and the lawyers have
23 underlined this to me time and time
24 again, is the regulation and

1 statute. If it says it directly in
2 the statute, it's clear, if it says
3 it directly in the regulation, you
4 must carry the following equipment,
5 it lists them, there's no excuses
6 there. If you don't have it, we
7 can charge you. And if AED is one
8 of those pieces of equipment, we
9 say then it should be on that
10 equipment list. We can argue that
11 if you have a protocol and you
12 don't have an AED to handle the
13 cardiac arrest, that's strong
14 enough. But frankly, my lawyers
15 say no. The lawyers over time have
16 always said the best thing they
17 like is to see a simple line in a
18 regulation for a piece of
19 equipment.

20 So keep that in mind. If you
21 want something to be absolute, you
22 know, and you shouldn't do it for
23 everything, because things change,
24 but absolute, then there should be

1 a modification to a regulation.

2 DR. MARSHALL: Yes.

3 DR. HAYDOCK: I'm not
4 sure what I want to say at this
5 point, but I agree with Dr. Dailey
6 and the fact that if it's in the
7 protocol, that that essentially
8 solves the problem. But this has
9 been -- I don't know how other
10 regions have dealt with this, but
11 this has been a nightmare out west
12 and has been a PR disaster from the
13 beginning, and I guess maybe from
14 me not being on this body very
15 long -- well, I'm not officially on
16 the body yet, but not being
17 involved for very long, I naively
18 took back the information after
19 every meeting and went full bore
20 trying to implement things, and
21 have now essentially had to
22 backtrack twice, and will now have
23 to go back and backtrack again, in
24 some sense, because of, you know,

1 our last REMAC meeting, we had a
2 long, lengthy discussion about an
3 agency that already purchased a
4 unit that didn't have the
5 recordable device, and we of course
6 deferred back to the state
7 advisory.

8 We've released an advisory to
9 our area that I know was forwarded
10 to the EMS office from the office
11 of OPC, and has gone back and
12 forth. And now I'm going to go
13 back again, and conveniently I have
14 a council meeting tomorrow night I
15 get to go to and try to explain
16 this again.

17 So I guess my only real
18 question would be, has this never
19 come up before? I mean, why are we
20 this far into this process and now
21 the lawyers are telling us that
22 everything this body has been doing
23 for apparently two years and being
24 very -- maybe sometimes

1 heavy-handed about it, it's like
2 well, you can't really do that
3 anyway, but you can because you
4 have protocol.

5 I mean, it's obviously pretty
6 frustrating for me. Maybe not for
7 others.

8 MR. WRONSKI: Well, I
9 think, Tim, you're correct but part
10 of the issue is that we never came
11 up with exact language until really
12 the fall of this year because the
13 language in the protocol -- not the
14 protocol, the advisory -- would
15 change over that two-year period of
16 time on a regular basis until we
17 had a final language.

18 So when I have a final
19 language voted on, then I send it
20 over to the commissioner's office.
21 But anything that the commissioner
22 is to review that requires his
23 endorsement and will really have an
24 enforcement capability because it

1 is establishing a standard goes to
2 counsel. And counsel in looking at
3 it just reminded me that the
4 advisories, all right, you can't
5 mandate something. You can help
6 establish a standard of care, but
7 you can't mandate it.

8 We've actually only issued
9 over the course of many years here
10 five advisories, I think, over the
11 years. So it's not that often.
12 And this one, I think, is simply
13 because it became a contentious
14 issue as well regarding the
15 equipment, and it was felt strongly
16 that we should mandate
17 implementation.

18 So I think what you take back
19 is the advisory is going to happen.
20 It's going to say capnography, wave
21 form capnography is the standard of
22 care for confirming tube placement.
23 But the only difference is an
24 actual mandated date can't be in an

1 advisory. But...

2 DR. HENRY: I don't think
3 it's quite as crazy as, you know,
4 it seems. We've been working on
5 this for five years. So, I mean,
6 the original advisories came out
7 after, quote, confirmation of
8 airways should be essential, you
9 know.

10 And it came out after the OA
11 paper that kids did just as well
12 with bag valve mask as intubation
13 in every other day trials, because
14 when you take in the esophageal
15 intubations, that really hurts that
16 part of the trial. Sort of like
17 the strokes and fibrinolytic
18 therapy pushes the favor into PCI,
19 because you have half the strokes.

20 So with that knowledge, there
21 was an option that it wasn't
22 essential to intubate children,
23 that bag valve mask was equally
24 effective, in the chance of a

1 misplaced tube.

2 So we had those advisories
3 stressing confirmation, and either
4 Ron Walls or Mike Murphy, one of
5 them said when they were asked to
6 write that section in our bible
7 here, they were going to put CO2
8 detection as primary confirmation,
9 not secondary, that there was --
10 that they -- internally about where
11 the text would flow, you know.

12 And I think we focused as a
13 group have hard on this. We asked
14 each region to go back and look and
15 establish confirmation of their
16 tube placement and we saw how
17 difficult that was in some areas to
18 do that. Some areas, even though
19 they tried hard, had difficulty,
20 and in the interim the technologies
21 changed. The technology is such
22 that portable devices are now
23 available which have gotten cheaper
24 and cheaper and very reliable, that

1 there's an option, there's a
2 technologic option.

3 Almost like AEDs came, and --
4 in the face of continuing
5 literature, and I would say need,
6 it's done by physicians and
7 hospitals where they've looked to
8 confirm QI studies or what have you
9 on placement, there's a continuing
10 need. And as a medical body we've
11 made a statement.

12 And we didn't say in the
13 advisory it was a mandate, and
14 it's -- if you look back in the
15 minutes from our last meeting, when
16 this came up, people said, if you
17 don't want to intubate, if you
18 don't have capnography, do bag
19 valve mask. That's clearly in the
20 minutes. So this has been
21 discussed.

22 So I think it's sort of
23 consistent. We used the avenue
24 that we have available. We could

1 have done other avenues. For all I
2 know, Dr. Dailey, council has voted
3 this through in the minutes, from
4 the motion from SEMAC; if we go
5 back and dig through the archives,
6 we may find that. But I don't know
7 that it's so -- that you have to
8 feel so awkward in terms of
9 returning, bringing information in
10 terms of a process we chose. We'll
11 use it in the future. I think
12 we've done something good. The
13 price fell at the vital signs, so
14 that people who are selling this
15 equipment, price has fallen almost
16 in half for some of the devices.
17 The fact that there's more of an
18 argument.

19 DR. MARSHALL: Dr.
20 Leinhart, do you have a comment?

21 DR. LEINHART: Sure.
22 I'll get it out there for general
23 discussion. I sort of regret that
24 we created a legal limbo for first

1 squads, you know, where we said,
2 okay, this is it, and, you know,
3 nice day at the lawyer's. I was
4 just wondering whether we could
5 create a mechanism that provides
6 some lead time to a mandate. I
7 remember a time when we didn't have
8 EMTs in the back of every ambulance
9 and we gave them five years to
10 comply with that.

11 This is a new standard.
12 Would it be protective and, you
13 know, satisfactory to this group to
14 incorporate it in a protocol, in a
15 minimum standard protocol, so that
16 all future regional protocols would
17 have it with some kind of lead time
18 for compliance as a way to
19 perhaps -- it is a mandate. If we
20 say that this is the standard of
21 care, we're not saying you have to
22 buy it, we're going to say you're
23 going to get hosed if you don't do
24 it. So it is mandated. So why not

1 incorporate it into our minimum
2 standard protocol.

3 DR. MARSHALL: One more
4 comment, then we'll close the
5 meeting and then --

6 MR. ZEEK: I think Dr.
7 Dailey's suggestion is very
8 reasonable, and I think the
9 interpretation of the advisory is
10 certainly reasonable and
11 appropriate, as Ed has discussed
12 it, and I think that people do want
13 to comply. I think you just have
14 to recognize the sort of
15 bureaucratic procedural obstacles
16 and the financial obstacles that
17 have to be overcome with some of
18 these things and give people some
19 time to get there.

20 But I think once somebody
21 does it in an area, it creates a
22 subtle competition and other people
23 want to follow suit, and I think
24 people really do want to comply,

1 and I guess you could set a date
2 out in the future, if you wanted
3 to. But I think that just
4 complicates it, and if the REMACs
5 want to make it a protocol, then,
6 of course, they have to comply.

7 DR. MARSHALL: Okay.

8 Thank you.

9 DR. OLSSON: I have a
10 noncapnography question.

11 DR. MARSHALL: Last one.

12 DR. OLSSON: Looking for
13 some direction and guidance. I was
14 approached by one of our pediatric
15 endocrinologists who apparently she
16 has a smattering of insulin
17 dependent kids throughout central
18 New York region and North Country
19 who are very brittle diabetics, and
20 whom IM glucagon won't work,
21 vascular access is lousy, and they
22 need, when they get into crisis,
23 albeit not very often, they need a
24 loading dose of IM sodium Cortep.

1 The parents have Solu-Cortep in
2 their home. They have the dose,
3 and they have all the instruments,
4 they have had the training.

5 However, apparently there are
6 enough parents who are squeamish
7 about giving the IM injection, and
8 therefore, prior to transport these
9 kids, how can we develop a
10 mechanism for the transporting
11 units to give that Solu-Cortep at
12 the dose that's already
13 predetermined.

14 We've made waivers for
15 interfacility transfers for
16 medications, provided the agency
17 medical director does the training,
18 signs off on it, etc. We can get
19 the training, and we're talking a
20 very small number of agencies. I
21 don't have the number. She's still
22 working on it.

23 But the question is, can we
24 do this through a policy statement?

1 Does it have to be a protocol or
2 what? Or is it not even possible?

3 DR. MARSHALL: It sounds
4 like it would probably be a
5 regional protocol since they're
6 already trained to give IM
7 medications, and Solu-Medrol is
8 probably already on the formulary.

9 DR. OLSSON: Solu-Cortep.

10 DR. MARSHALL: That might
11 be something that might be
12 reasonable. I don't know. That's
13 something that you want to --

14 DR. DAILEY: How would
15 this be different than any other
16 assist the patient with their
17 medication? In some cases these
18 will be continual drips that they
19 may break a central line and we may
20 need to continue to do that drip.
21 It may be other home infusions
22 where what we're doing is
23 facilitating the -- of the line.
24 But in this case this really just

1 sounds like assist the patient with
2 their medication. Their
3 medication, all you're doing is
4 following their direction. It's no
5 different than a BLS provider doing
6 this sort of thing.

7 DR. MARSHALL: Dr. Funk?
8 And then maybe we can take this
9 offline.

10 DR. FUNK: Should we
11 write an advisory that suggests
12 that in this day and age of
13 advancing medical equipment and
14 medications and all that is
15 suggesting that if a paramedic or
16 whoever arrives on the scene,
17 there's something the patient says
18 they need, medical control is
19 contacted, they get the orders to
20 do whatever is right, including say
21 Cortep or Flolan or Dobutamine or
22 whatever, you know, Elvet pumping
23 needs to get done.

24 MR. WRONSKI: Med control

1 is always an option. The caveat is
2 med control needs to understand the
3 capabilities of the particular --
4 but I would think med control in a
5 case like this, if that's
6 available, is clearly an option.

7 But I would agree with the
8 chairman that we can discuss this
9 offline and we can always, if need
10 be, bring back the SEMAC this
11 afternoon.

12 DR. MARSHALL: Thank you
13 very much. We'll adjourn until
14 this afternoon.

15 (Time noted: 10:48 a.m.)

1 STATE OF NEW YORK :

2 COUNTY OF COLUMBIA :

3

4

5 I, JOSEPH A. ADAMKIEWICZ, C.S.R.,
6 Certified Shorthand Reporter and Notary
7 Public of the State of New York, do
8 hereby certify that the foregoing is a
9 true and accurate transcript of the
10 proceedings reported by me, to the best
11 of my knowledge and belief, in the
12 matter held on December 2, 2008.

13

14

15

16

17

18

Joseph A. Adamkiewicz,

19

C.S.R.