NEW YORK STATE
DEPARTMENT OF HEALTH

MEDICAL STANDARDS COMMITTEE

June 9, 2009
8:35 a.m. - 11:40 a.m.
Crowne Plaza Hotel
Lodge and State Streets
Albany, New York

BEFORE:
Lewis Marshall, M.D., Chair

DR. MARSHALL: Good morning, everyone. A little housekeeping before we begin. Your nameplate is on the way, so, please, before you make your comments, raise your hand to be recognized and then state your name so that we can get it on the record and contribute the comments to the guilty party -- I mean commenter.

We'll start the meeting now. If you'll please take out your agenda that was sent to you. Ball it up and throw it away. It's changed about 50 times since you got that, so whatever is on there is probably not going to be on there, and the one I have from yesterday has changed. See? So we'll work from my agenda, and I apologize in advance if things seem a little disconnected because they are disconnected this morning.

So to begin with, in the past we had some discussion and a presentation from a group talking about glucocorticoids in prehospital care for certain patients. We had asked the EMS-C group to take a look at that and come back with some recommendations, and Dr. Cooper is

going to give us those recommendations this morning, first.

DR. COOPER: Thank you, Dr. Marshall. I am, of course, as I speak, circulating around the room and passing out the appropriate documentation. The short of it is that congenital adrenal hyperplasia and other conditions that predispose to acute adrenal insufficiency do result in circumstances that can pose an immediate threat to life and health, particularly in kids who are victims of these conditions, which is why the Cares Foundation, particularly, was interested in the children of our state and why Dr. Henry and Dr. Marshall directed that the EMS-C subcommittee have an opportunity to review the situation.

The EMS-C committee did meet with the Cares Foundation folks on Tuesday, March 17, and had an opportunity to question them at length and came up with a preliminary proposal which was, actually, discussed at its meeting of June 2, one week ago today. And the EMS-C committee voted unanimously to recommend to the SEMAC, through Med Standards, that it consider the

addition of measures that would allow administration of glucocorticoids in the field to children and potentially adults with congenital adrenal hyperplasia and other conditions predisposing to acute adrenal insufficiency, but under a prescribed set of circumstances.

Before I iterate those circumstances, which, of course, are outlined in the letter which I'm distributing to you, let me just state that the State of Rhode Island has considered the same issue and has adopted, virtually, the same type of approach as we are considering today, and I am told that the State of Nevada is also considering this approach.

Specifically, for kids to be -- and adults, by the way, should the SEMAC so decide -- to be considered for gluco-corticoid therapy, they would first have to be identified as susceptible to this condition through the wearing of a medical bracelet or some other device that clearly identified them as patients susceptible to this condition. Clearly, it's not a diagnosis that can be made in the field,

1 de novo, and even among children with the
2 condition and making a determination as to
3 whether a child is in immediate danger of life
4 can be difficult to determine.
5 Second, after the child is identified as
6 having a condition predisposing to congenital
7 adrenal hyperplasia by the wearing a bracelet,
8 or similar means, the child must be identified
9 as having one or more findings typically
10 associated with actual or impending adrenal
11 insufficiency including, but not necessarily
12 limited to, fever, shock, trauma, altered mental
13 status or hypoglycemia.
14 Third, all the usual treatments that
15 would be provided in the field for a patient in
16 impending crisis -- oxygen, volume
17 resuscitation, intravenous dextrose -- should
18 have been administered in age-appropriate doses,
19 unless glucometry indicates that that's not
20 necessary.
21 And last, of course, the steroids must
22 be available on the ambulance or advanced life
23 support, first response unit.
24 Now, there are two reasons that the

1 EMS-C subcommittee felt that this was important
2 to consider, and a third that is not actually
3 iterated in the letter, the key issues are, of
4 course, that there is very high morbidity and
5 mortality associated with delayed recognition
6 and treatment.
7 The second, the downside of it,
8 administration of a single dose of steroids is
9 virtually nil. So there is, really, tremendous
10 upside, no downside, to administration of the
11 medication.
12 The third issue has to do with volume.
13 And while we do not have exact numbers, the
14 preliminary data that we do have available to us
15 does indicate that the numbers of patients that
16 are susceptible to this condition, at least,
17 approximates the numbers that might be
18 susceptible to anaphylaxis due to peanut
19 allergy, bee stings, and so on, for which we've
20 already taken a position that epi-pens are, you
21 know, appropriate and necessary to the
22 responder.
23 Now I think the one issue that is of
24 some concern is, really, whether providers can

1 assist patients with self-administration of
2 their own medications, particularly, if they're
3 not sort of in a kind of mental status that
4 would allow them to direct that the crews
5 assist. Well, first of all, in the main, we're
6 speaking about children here, and I think the
7 position of the Department in the past, at least
8 from what we were advised at our recent meeting,
9 was that when a child has a medication that's
10 previously prescribed and a parent or someone,
11 like a school nurse, is in close proximity and,
12 clearly, knows that that is the child's
13 medication, that it has been prescribed, that it
14 is appropriate to assist the child with the
15 medication, that the term "self-administration"
16 in that case would extend to -- the authority to
17 authorize that would extend to the parent.
18 And, of course, last, but not least,
19 while, you know, we're not advocating that
20 hydrocortisone be carried on ambulances,
21 necessarily, it is the drug of choice. It has a
22 little bit better mineral corticoid activity, as
23 you know, the methylprednisolone.
24 Methylprednisolone, in the high doses used, does

1 have sufficient mineral corticoid activity, you
2 know, to be effective as a substitute. So
3 either could be used. Even though the mineral
4 corticoid is a very stable medication, it does
5 not require refrigeration, is very inexpensive
6 and could be carried on ambulances at minimal
7 additional cost. So for all the reasons, you
8 know, I've presented, the state EMS-C
9 subcommittee did feel unanimously it was
10 appropriate for the Med Standards committee,
11 SEMAC and SEMSCO to consider authorizing the
12 addition of this particular step in protocol,
13 should, in its wisdom, so decide.
14 DR. DETRAGLIA: John DeTraglia from
15 Utica. Can this be given IO, and shouldn't that
16 be included in the protocol?
17 DR. COOPER: The specific
18 instructions as to how administer the drug, or
19 the writing of a protocol, we felt was beyond
20 the charge that was given to us by the chair.
21 Were we asked to write specific protocol
22 language, yes, of course, it could be given IO,
23 IV, or, in fact, in most circumstances, it's
24 given IM.

1 DR. DETRAGLIA: The second question
2 is dose-related. It sounds to me that when we
3 gave -- many years ago, when we gave shock doses
4 of steroids -- many years ago, when we gave
5 shock doses of steroids, we would give 3 and 4
6 and 5 grams to an adult. Is there a downside to
7 just giving 100 milligrams to everybody?
8 DR. COOPER: You know, again, the
9 therapeutic-to-toxic ratio with this drug is
10 quite wide, so there is, really, no particular
11 downside; however, what we have done is utilize
12 the most current recommendations in the text
13 books of pediatric emergency medicine and
14 pediatric critical care medicine, you know, the
15 doses that are currently used in emergency
16 departments and in pediatric ICUs for
17 administration of these medications. So, you
18 know, these are pharmacologic doses, rather than
19 physiologic doses, of the medication that are
20 recommended. And you will all see, a table of
21 equivalency has been provided in the letter.
22 DR. FAIRBANKS: I just want to
23 clarify because --
24 DR. MARSHALL: State your name,

1 please.
2 DR. FAIRBANKS: Terry Fairbanks,
3 University of Rochester. You said that your
4 committee says it's appropriate for us to
5 consider. Can you -- which I think we are
6 considering, but can you clarify whether it's
7 the recommendation of your committee that we
8 make a protocol to allow for this?
9 DR. COOPER: It is the
10 recommendation, but under Article 30C we have
11 the right only to recommend to you, not that you
12 consider it, not that you, you know, adopt it,
13 per say. So, yes, it is our recommendation that
14 this be included in the protocol, but that's
15 SEMAC's decision to make, subject to approval by
16 the SEMSCO, upon the recommendation of this
17 body.
18 DR. MARSHALL: Yeah, Dr. Henry.
19 DR. HENRY: Were you able to
20 identify with your group of doctors, a lot them,
21 tertiary pediatric hospitals, how many cases
22 they know of where they didn't get this in the
23 field? And, also, what is the, you know,
24 relative difference in therapy that's given in

1 the field or 10 minutes later in a hospital?
2 DR. COOPER: Let me answer the
3 latter question first. The experts on the
4 committee had only anecdotal evidence to provide
5 in terms of the efficacy of the urgency of
6 treatment, but all felt it should be given as
7 soon as possible after a diagnosis had been made
8 and therapy had been initiated.
9 With respect to number of cases in the
10 field, no one appears to have that information,
11 in part, because it's not tracked at the present
12 time, but they did identify that as many as 12
13 to 1,800 cases of congenital adrenal hyperplasia
14 are identified every year -- or not, sorry,
15 congenital adrenal hyperplasia and other
16 conditions predisposing to adrenal insufficiency
17 statewide. How that plays out in terms of
18 hospital visits, emergency department visits,
19 that information, I do not have available for
20 you. They did not have it available for us.
21 DR. HENRY: Could you inquire of
22 SPARCS to see if you could get that from ED
23 visits or for hospital visits?
24 DR. COOPER: I don't see why not.

1 I think that could be done. Yes.
2 DR. OLSSON: Dan Olsson, Central
3 New York. Almost a year ago, I brought this up
4 either formally or informally, I don't remember,
5 because one of the endocrinologists in Syracuse
6 approached me about it. And the gist of the
7 conversation ended up was that this fits within
8 the scope of practice to assist patients in
9 giving their own medication. The way it was
10 outlined to me was that these kids, of which
11 there are two in Cayuga County in all of the
12 five counties of Central New York region and a
13 couple more scattered in the North Country, they
14 get into this situation; they need this, they
15 need the drug right away, and the parents are
16 too squeamish to give it. And the intent was to
17 have EMS arrive, administer the drug and then
18 transport them, and it was felt then that this
19 was well within the scope of practice already.
20 I then asked Dr. Stroud, who is the
21 endocrinologist -- or, excuse me, I informed her
22 of what the decision or the discussion was, to
23 provide me with the names and locations of the
24 patients, and we will inform the agencies, and

1 we will make it known that the providers, when
2 they're called, can administer the whole
3 medication and transport. And it was the last I
4 ever heard of that until they came to this
5 meeting. So, personally, I think it fits well
6 within scope of practice. As I understand it,
7 the numbers are miniscule, and I would be
8 reluctant to add another drug to the ambulance,
9 no matter how little it costs, but that's my
10 opinion.
11 MR. WRONSKI: If I could just add
12 to that information. Prior to Dr. Cooper coming
13 in and the meeting starting, I had a sidebar
14 with myself, Dr. Morley was at the meeting, and
15 a couple of the emergency pediatricians who were
16 there. And they indicated it was small numbers
17 that they had seen, but one of them, Dr. Lillis,
18 was, you know, very strong in her opinion about
19 the need to do this, because the giving of the
20 drug quickly, she felt, was critical, and that
21 it is a small number. She had experiences with
22 a couple of patients where, when they get the
23 drug, for them it's a miracle drug; it works
24 immediately. So she strongly supported it, but,

1 clearly, no one had numbers. And I think, even
2 the Cares Foundation would say that even when
3 you look statewide, and there are 12 or 1,500
4 patients that are known, when you put that into
5 the pool of EMS of 2.7 million transports, it's
6 a drop in the bucket, literally. So the
7 question for you is when EMS-C comes across such
8 a patient, what do they need to know? What can
9 they do? Does it require a formalized protocol
10 to require you to carry a drug, or does it
11 require something else, and it's your
12 recommendations, but it is a small number of
13 patients. We're not talking large numbers.
14 DR. COOPER: Just in follow-up to
15 this last comment, I should just add that, in
16 addition to Dr. Stroud, there was a letter
17 provided to the subcommittee, signed, as best I
18 could tell, by virtually every pediatric
19 endocrinologist statewide, so it does appear to
20 have a reasonably broad level of support.
21 DR. GOODMAN: Carl Goodman, Suffolk
22 County. Is this on? Two questions. Can you
23 just --
24 DR. MARSHALL: State your name,

1 please.
2 DR. GOODMAN: Carl Goodman, Suffolk
3 County. Can you just clarify what you mean by
4 assist? And the second question is, why would
5 we limit it to just parents or duly authorized
6 caregivers? If a kid collapses on a sports
7 field and there is no nurse or no parent
8 available, you know, shouldn't EMS be allowed to
9 administer this medication, as well, if it's
10 prescribed for the child?
11 DR. COOPER: With respect to the
12 term "assist," that's meant in the same way we
13 use the term, you know, in the system, broadly
14 speaking, assistance with self-administration of
15 medication. In whatever way that is normally
16 interpreted by the system, it's not meant to be
17 limiting in any sense. And, similarly, the term
18 "duly authorized caregiver," such as a school
19 nurse, is not meant to be limiting either.
20 Certainly, if a child collapses on an athletic
21 field, and is known to have this condition, and,
22 you know, the school knows of this condition,
23 would have the authority to assist if the school
24 nurse were there, you know, that, I am,

1 virtually, certain the committee would believe
2 constituted a duly authorized use of the drug
3 and within the meaning of this language.
4 MR. WRONSKI: What I will add is
5 any caregiver, who is the recognized caregiver
6 for the child, can do that. I know this
7 organization had also asked that if a child is
8 wearing a bracelet that identifies them, that we
9 follow that. And that's a question, you know,
10 maybe for you. Are you comfortable with that?
11 If a child has a medic alert bracelet and it has
12 specific information, and you would look for the
13 medication, say there is no one there, you know,
14 would you be comfortable with EMS making that
15 call at the scene? But, clearly, anyone who is
16 in charge of that child and is the caregiver at
17 that moment would be. And they have to identify
18 themselves; I'm the sports coach or whatever.
19 DR. MARSHALL: Dr. Funk.
20 DR. FUNK: I think it's appropriate
21 for us to just keep in mind that the population
22 of patients that would benefit from an emergent
23 administration of steroids is much larger than
24 this population that we're talking about now.

1 Anybody who is on chronic steroids and is in
2 shock needs steroids immediately and would
3 benefit just as much, I think, as any of these
4 children. And if you think of all of the people
5 who have COPD, or have is asthma that is poorly
6 managed, all the people who are on prednisone
7 every single day, that's the number of patients
8 that we're talking about. How many of us have
9 seen somebody who was in adrenal crisis and
10 actually remembered to give them their steroids?
11 You know, it hasn't happened to me that often,
12 whether I didn't recognize it immediately or
13 whether I've truly never seen it that often, I
14 don't know. But I think that we're talking
15 about a larger population of patients than just
16 this, you know, the children with CAH.
17 The second thing is it's wonderful that
18 the committee, EMS-C, has put together this
19 summary and clarified for us whether it's just
20 hydrocortisone that would be useful or
21 Solu-Medrol, also, because many regions already
22 carry Solu-Medrol, and many regions teach their
23 paramedics already what's it for, you know, how
24 to administer it and what the dosage is. And

1 the dosages that we're currently using for
2 asthma and other inflammatory things and
3 anaphylaxis would cover this. And I would say
4 the doses, the 125 of Solu-Medrol for an adult,
5 is more than the 20 milligrams that's going to
6 be equivalent to the hydrocortisone, 100
7 milligrams, but it's not harmful because we
8 already give it to everybody. I don't think
9 that this is going to be a change in anything
10 but adding an hour of education to regions'
11 continuing education training. I think this
12 would be a very small change that could advance
13 the education and practice of ALS providers and
14 benefit way more patients than what we're
15 talking about right here. So I would recommend
16 that we support an educational effort and, in
17 addition to our protocol, to allow steroids to
18 be used for this indication since it's already
19 being used for other indications right now. It
20 sounds like the question, I would bet, that the
21 people who are pushing the steroids for CAH
22 patients will also be looking for BLS
23 administration and assistance. If it were me
24 and that were my child, that's what I would want

1 to see happen, but I think's that a whole
2 another question. I think asking -- doing the
3 training and adding a protocol for ALS is
4 simple, in my mind.
5 DR. COOPER: Actually, the Cares
6 folks are not asking for BLS administration at
7 this particular point in time; there is no ready
8 mechanism to do so. But the committee is, of
9 course, asking that appropriate training would
10 have to be provided, if this were adopted.
11 DR. MARSHALL: Dr. Kugler and then
12 Mr. Delagi, and then I saw another hand over
13 here.
14 DR. KUGLER: Yes, Dr. Josh Kugler,
15 Nassau County. I appreciate Dr. Cooper's work
16 here on the subcommittee and bringing it to our
17 attention, and I also appreciate Dr. Funk's
18 comments about the broad applications of steroid
19 use for multiple disease entities. My only
20 concern here is that, while congenital adrenal
21 hyperplasia has many different forms, most
22 common being a 21 hydroxylase deficiency, there
23 are other forms of it. My concern is, when
24 you're talking about a child's age person, a

1 child out in the field playing sports, the
2 treatment of a child who collapses on the field
3 should not be application of mineral corticoids.
4 And I think we're forgetting this is a salt
5 wasting disease. The treatment for that
6 hypotensive, shocky kid is immediate
7 administration of isotonic saline solution. So
8 I just want to go on record that we understand,
9 as medical providers here, that it's an
10 important thing to give steroids to diagnosed
11 individuals with steroid deficiency or adrenal
12 insufficiency, secondary to a disease stage
13 stress, other things, but it's also critically
14 important to make the proper diagnosis so that
15 we don't tunnel vision, start hitting kids who
16 have a diagnosis of adrenal insufficiency or
17 congenital adrenal hyperplasia and cause more
18 harm. So, I agree, there's a very good safety
19 profile on these things; I'm just concerned that
20 we're going to miss a bigger picture.
21 DR. MARSHALL: Well, one of the
22 recommendations is is that the child receive
23 those things before receiving glucocorticoids.
24 DR. COOPER: That's correct.

1 DR. MARSHALL: And that's spelled
2 out in their recommendation, so that is correct.
3 You're absolutely correct. Bob?
4 MR. DELAGI: Thanks, Dr. Marshall.
5 Bob Delagi, Suffolk County. I just wanted to
6 quickly add to the comments that have already
7 been stated. We've had some experience with
8 this in our own region dating back to 2005, and
9 renewed again after Ms. Brown's last visit to
10 our group here last September. And with regard
11 to the training, it is a very simple thing to
12 do. Every pediatric endocrinologist that we've
13 spoken to was more than willing to come in and
14 provide the training. In fact, they did provide
15 some training recently for one agency in our
16 region with two children that have CAH. And it
17 was about an hour long, very simple, very easy
18 to understand. The scope of practice issues,
19 certainly, make this something well within the
20 scope of an ALS provider. And then, finally,
21 with regard to the cost effectiveness, at least
22 in our region, the families agreed that they
23 would just provide the ambulance with the
24 medication, so the cost is really, in our

1 experience, a non-issue. So from the
2 prehospital perspective, I would just like to
3 speak in support of this measure.
4 DR. MARSHALL: Thank you. Yes.
5 DR. COOLEY: Craig Cooley from the
6 Western region. I think those issues about the
7 broader issues of steroids are very important,
8 but in this specific case I think it's been
9 mentioned repeatedly about two children in a
10 region, one child in a region. And as someone
11 who has very personal knowledge of this subject,
12 the parents are usually very well informed about
13 this and are very active because it's a very,
14 potentially -- no matter which form you have --
15 the 21, the 17 or the 11 -- it's potentially a
16 very significant issue. I will say that, in my
17 personal experience, it doesn't come on quite as
18 quickly; except in rural areas, I would wonder
19 about the general use of prehospital on the few
20 minutes, as long as the emergency department has
21 recognized the situation. It wouldn't make that
22 much difference, but when you are talking about
23 rural areas, it's probably an important thing,
24 but I don't want us to get too far into the

1 weeds and have EMS suddenly looking for every
2 kid out there that might collapse on the field,
3 that they need steroids, as was mentioned.
4 These cases, they're far and few between. And
5 unlike unfortunately other health situations,
6 the parents are usually very well informed. So
7 in a situation like that where they have their
8 own medication, or they can provide it to that
9 local agency, it shouldn't -- it seems to be
10 well within the scope of practice.
11 DR. MARSHALL: It seems that, for
12 the most part, around the table it's the
13 consensus that this is a reasonable request from
14 EMS-C, and so I guess what we should do is
15 entertain a motion to accept the recommendations
16 of EMS-C and move it forward to SEMAC that
17 regions develop a protocol that will allow for
18 the administration of glucocorticoids to these
19 children with these diseases and, possibly,
20 other patients. Dr. Funk.
21 DR. FUNK: Would you accept an
22 amendment to your suggested motion that perhaps
23 we develop that protocol here and give it to the
24 regions so that it's the same all over the

1 place? It's just a thought.
2 DR. DAILEY: Actually, reading the
3 recommendation here, actually, this would be
4 added to the New York State Advanced Life
5 Support Prehospital Treatment Protocol, so where
6 does that leave us? And my only other
7 recommendation would be, if we do make a
8 statewide protocol, which seems to be
9 Dr. Cooper's suggestion, which I think is a
10 great idea, I would ask that it be a weight-base
11 dosing.
12 DR. MARSHALL: Just before we move
13 on with that, I guess now is as good a time as
14 any. In terms of our previous discussions
15 regarding whether or not SEMAC can establish
16 standards or protocols, the DLA is now reviewing
17 that whole process, de novo, I suppose, due to
18 additional information that they've come up
19 with, so whether we can, actually, do a
20 statewide protocol at this time, or a statewide
21 standard, and there is some other discussion
22 that goes along with that. But I mean, from our
23 point of view, I think that we should have a
24 state -- my point of view, I think we should

1 have a statewide standard.
2 MS. CHIUMENTO: I think there is
3 another option also, and that is, instead of a
4 having a protocol, specifically, to this
5 process, to this disease, we could add it in as
6 a regional or medical control option under shock
7 and under hypoglycemia. So the symptoms, do it
8 to the symptoms instead of having it as a
9 separate entity. I think that would make it
10 more sensible for the EMS providers, because
11 unless they actually know what they're dealing
12 with and go find that particular protocol,
13 they're much more likely to think of it if it's
14 within one of the other protocols that they're
15 already using.
16 DR. MARSHALL: Yes. Dr. Cooper.
17 DR. COOPER: I stand corrected with
18 respect to Dr. Dailey's comment. I use the term
19 "protocol" in a generic sense, rather than in a
20 specific legal sense in which she's raising it.
21 As we understand the issue at the present time,
22 yes, SEMAC has the right to establish protocol
23 standards for statewide implementation;
24 although, the protocol implementation, per say,

1 is at a regional level. So what the EMS-C
2 subcommittee is suggesting is a, if you will,
3 guidance to the regions in terms of how to
4 proceed with this. I believe that the
5 suggestion that been made by Ms. Chiumento is a
6 perfectly acceptable and appropriate one, but
7 before the committee went so far as to perhaps
8 accept guidance from this group as to whether it
9 wanted specific protocol language developed, we
10 felt we should bring the issue forward to the
11 committee for discussion beforehand. If it's
12 the committee's wish that we come back with
13 specific language, as Ms. Chiumento suggests, we
14 can do that, but I will make the motion on
15 behalf of the State Emergency Medical Services
16 for Children Advisory Committee that these
17 recommendations be adopted with the
18 understanding that the term "protocol" means
19 protocol standard.
20 MR. WRONSKI: If I could just -- it
21 might be, you know, prudent for the committee to
22 make the following motion Dr. Cooper recommends
23 and that could be shared with the region to
24 review this locally. I think, certainly, before

1 we get to the point of whether we're going to
2 write and finalize the State either protocol or
3 standard, that's going to take some time, but I
4 think the SEMAC should say what it thinks about
5 this particular issue, you know, for the record
6 so REMACs understand that. And they're always
7 free to do something locally in the interim.
8 Just to clarify regarding the issue with
9 DLA, there's no change in their basic opinion
10 that the law supports that the SEMAC sets the
11 statewide standard, but there are other issues
12 that are also involved, and I think I alluded
13 them to last time. One of them was, if you
14 write a regional protocol, do you have the right
15 to enforce it to say that, you know, you -- if
16 somebody doesn't? Is that enforceable? And
17 there is a question that's been raised at the
18 hearing level. And so DLA, myself and Andy and
19 two lawyers met to walk through this once again,
20 and they're putting house counsel, the direct
21 house counsel has decided to put together an
22 independent TAG of specific lawyers who had
23 expertise in some of these things, not just
24 Article 30, to review our process; how we do

1 things and what the law and the regs currently
2 say so that they will give, you know, final
3 advice on the process, not the right to set a
4 standard, not the right of the regions to write
5 protocols, but the process of how you get that
6 approved, and so that, if it gets challenged, it
7 clearly is supportable, which could take you all
8 the way to a court of law in some cases. So,
9 you know, that's still being worked on. But,
10 for the moment, on this specific issue, my
11 recommendation is to, at least, make sure the
12 SEMAC's voice is heard as to what they think
13 about this.
14 DR. MARSHALL: Okay, Dr. Funk.
15 DR. FUNK: Perhaps, writing a SEMAC
16 advisory with the suggested guidelines would be
17 the very easy way to get this done quickly
18 instead of continuing to figure out what form it
19 should take. We know a SEMAC advisory is
20 something that we can do, and it can discuss it,
21 describe it, give suggested education points and
22 then suggested ways to put it into the existing
23 hypotension, shock and hypoglycemic protocols.
24 DR. HENRY: I think that we could

1 follow a normal process and not do that. I mean
2 advisories, to me, are something, if it doesn't
3 go through the counsel or, for whatever reasons,
4 SEMAC chooses to make its voice known, that's an
5 avenue with the signature of the Commissioner.
6 But here we're talking about a protocol, and I
7 think it would be helpful, given the discussion
8 for, perhaps, EMS-C to clarify, though it seems
9 pretty clear to me, exactly how this would work.
10 I mean I think we're talking about people with
11 identified conditions, correct?
12 DR. MARSHALL: Correct.
13 DR. HENRY: Or bracelets or other
14 means to identify them. And then from there, is
15 there a need? And, first, they would be
16 assisting with their own medication. If they
17 don't have a medication, then another commonly
18 carried medication on the ambulance that would
19 have some emphasis. Am I correct with that?
20 DR. COOPER: You are absolutely
21 correct.
22 DR. HENRY: So that's -- and think,
23 educationally, it's important to have some sense
24 of types of patients, actual examples, what the

1 numbers are so that people keep it in the right
2 perspective and people don't think that every
3 child who has trauma is a candidate, but rather
4 they're looking for bracelets and recognizing
5 what that might mean. I would ask EMS-C to --
6 well, I think it, actually, is pretty clear in
7 here.
8 DR. MARSHALL: We can do that. So
9 do we have a recommendation to accept the report
10 of EMS-C and to move it forward to SEMAC?
11 DR. COOLEY: Craig Cooley, Western
12 region. I guess I kind of question, again,
13 making this a specific protocol. I think the
14 suggestion of making it as education and knowing
15 that it's out there and working in the region,
16 but I mean aren't EMS groups supposed to be
17 looking for medical bracelets already, and
18 aren't they supposed to calling the medical
19 control if they run across one that they don't
20 recognize? And so I mean I would just fear --
21 be a little fearful of making a protocol
22 specific to this, and then the next disease
23 process that has a specific treatment, we have
24 another protocol, I mean especially when we're

1 talking a very small number of patients. Don't
2 get me wrong, I want my steroids to keep on the
3 tree, but --
4 DR. HENRY: Well, can I just
5 respond to that? I think that is a good
6 suggestion, and I think in terms of the assist,
7 there is a standard format in BLS and ALS
8 training in how one assists with medication, and
9 you're supposed to know certain things about
10 each medication, so an educational format, I
11 would think, would follow that. Indications,
12 contraindications, adverse effects, dose range,
13 and that should be part of the educational
14 component.
15 DR. MARSHALL: Dr. Cooper.
16 DR. COOPER: Yeah, I do think that
17 it would be -- and I think the EMS-C
18 subcommittee would feel that it warrants,
19 perhaps, a little greater visibility than
20 education and a discretionary decision. If it's
21 not written on a printed page somewhere in terms
22 of a protocol option, it can tend to slip
23 between the cracks. So that's why we did
24 recommend that it be in some way, shape or form

1 included as part of a protocol language. But I
2 think we're really -- we're really talking more
3 style and substance. I think no one disagrees
4 about issue; it's really a matter of how best to
5 accomplish it. So I would be most comfortable
6 knowing the debate that took place at the EMS-C
7 subcommittee to, you know, follow Dr. Henry's
8 initial suggestion that we come back with some,
9 you know, suggestive language at the next
10 meeting. But I think Mr. Wronski's suggestion
11 that the SEMAC go on record in terms of
12 supporting this administration of -- excuse me,
13 supporting the assistance with
14 self-administration of previously prescribed
15 corticoid steroids in this condition, you know,
16 would be very useful.
17 DR. MARSHALL: Yes.
18 SPEAKER: Second the motion.
19 DR. MARSHALL: Thank you. Any
20 other discussion? The motion to accept the
21 report of the EMS-C and move it forward to
22 SEMAC. Yes.
23 DR. OLSSON: Dan Olsson. Just in
24 some regions, especially Central New York, we

1 don't carry steroids, and don't have plans to
2 any time soon. So I would just ask that that be
3 clear for agencies that don't have it, that they
4 can just assist. And, again, once again, it's
5 duplication. What if the medic's dose differs
6 from the parent's dose? So I think there just
7 needs to be clarification. I'm all for it.
8 Don't get me wrong, but I think it needs to be
9 very well spelled out.
10 DR. COOPER: Thank you. Those are
11 important points, and the EMS-C committee
12 understands that the drugs are not available in
13 regional formulary in various parts of the
14 State, and it is not necessarily suggesting that
15 the SEMAC should advocate that it be mandatory
16 in the statewide formulary.
17 DR. MARSHALL: Any other
18 discussion? All those in favor of the motion,
19 raise your hand. Opposed? Abstained? The
20 motion carries unanimously. Thank you,
21 Dr. Cooper.
22 DR. COOPER: Thank you, Dr.
23 Marshall. I have two other items to bring
24 forward from the EMS-C subcommittee, and both

1 are, I believe, relatively straight-forward.
2 The first has to do with a discussion that took
3 place at our March meeting and focused on the
4 issue that the protocols in many regions of our
5 state have become increasingly complex over the
6 years and that, particularly, for infrequently
7 applied protocols, that memories may not always
8 be perfect as to which step follows upon the
9 next one. And it seemed prudent that we, as a
10 SEMAC, recommend that all ambulances be directed
11 to carry copies of the protocols on board.
12 That's one item.
13 The second item has to do with the
14 NEMSIS data set. Lee Burns was kind enough to
15 provide us with an update as to where the
16 Department stood with respect to adoption of
17 NEMSIS. And as many of you know, or will hear a
18 little bit later today, the Department is
19 proceeding with adoption of at least some part
20 of the NEMSIS data set and data dictionary in
21 New York State so we can compare our performance
22 with those of other states, and the EMS-C
23 subcommittee strongly endorses that approach.
24 So there is no action required on the

1 latter point, and I leave it to the discretion
2 of the chair of this committee and the SEMAC as
3 to how it wishes to proceed with respect to our
4 recommendation that a copy of the protocols be
5 available on every ambulance and advanced life
6 support, first response unit.
7 DR. MARSHALL: Thank you,
8 Dr. Cooper. I think I'd add, with the increase
9 in complexity of the protocols and the standards
10 as we develop them and new technologies and
11 medications become available in the prehospital
12 setting, that any prudent medical director would
13 insist that there be one copy on every ambulance
14 that transports patients. Whether or not we
15 need to make that a requirement or not, I don't
16 know. I'll leave that to SEMAC, I think.
17 DR. COOPER: That's fine with me.
18 Should I then bring this up under new business
19 at SEMAC this afternoon or should we --
20 Dr. Henry.
21 DR. HENRY: Get a sense here.
22 DR. MARSHALL: Yeah, let's get a
23 sense in here, yeah. All right, it's a strong
24 poll. All those who think that a copy of the

1 protocols should be on every prehospital -- on
2 every ambulance transporting patients and
3 advanced life support first response unit?
4 Okay, there you go. Thank you so much, okay.
5 So that was -- that was unanimous, I thought,
6 yes?
7 DR. DAILEY: Should it be easily
8 accessible or with the short port?
9 DR. MARSHALL: You have the
10 electronic copy, the short version and the long
11 printed version, no.
12 DR. COOPER: In both standard and
13 protocol formats, Dr. Dailey.
14 MR. WRONSKI: If I could just
15 comment on that. You know, one of the things
16 that SEMAC and the state council do is not
17 simply complex medicine, but sometimes make a
18 recommendation that has a bigger impact, which
19 is really simple things. And any good ambulance
20 service is managed so that you take the
21 information to the scene that you need to take,
22 and, particularly, in ALS there are -- it is
23 becoming much more complex, so it really is not
24 just prudent, it's just smart to bring that

1 protocol with you. Some medics carry a small
2 one that they have with them, but there really
3 should be one on the rig, and it's not an
4 imposition; they're available. It's no real
5 space, and it should be common that it's there.
6 I think the state council will support that,
7 too.
8 DR. MARSHALL: Yes.
9 MR. DAVIDOFF: Just a quick
10 comment, too, that many vehicles nowadays have
11 computers on board, and it's very easy to load
12 an electronic copy that can be upgraded. We can
13 save a lot of money on paper and allow for quick
14 upgrades that way as well. So there's multiple
15 ways of having these copies available. A lot of
16 medics carry PDAs. With the memory involved in
17 the PDAs nowadays, they can carry them in their
18 PDA, but I think a copy should be available.
19 DR. MARSHALL: Any other comments?
20 Lee.
21 MS. BURNS: From our position --
22 Lee Burns with the Health Department. On the
23 lighter side I think that, as your protocols get
24 more and more complex and the provider group

1 gets older and older, I mean it makes practical
2 sense, but from our position in the Health
3 Department, as we look at complaints and we talk
4 with the REMACs and we talk with the regions,
5 there's a lot of quality assurance issues that
6 are coming up, just simple protocol error. Some
7 of our more serious enforcement actions are
8 either omission or commission of your protocols.
9 And I think, you know, as a provider myself, I
10 have come to realize that I do need bifocals,
11 and that I do need to carry the book, and I do
12 look at it. So I think it is prudent. I think
13 we should encourage our providers to carry their
14 protocols.
15 DR. MARSHALL: Okay, thank you.
16 All right, I'd like to move on. The next item
17 on the agenda is Nassau REMAC protocols.
18 Dr. Kugler and Mr. Hassett, do you want to --
19 these were, actually, left over, I believe, from
20 the February meeting, and the protocols include
21 a hospital diversion ambulance redirection
22 policy, adult nerve agent organophosphate
23 poisoning anecdote protocol and a pediatric
24 nerve agent, organophosphate poisoning anecdote

1 protocol. Dr. Kugler?
2 DR. KUGLER: Sure, thank you. My
3 only comments -- again, Dr. Kugler from Nassau
4 County -- for that. I regret that we're
5 following such a nice -- discussion by
6 Dr. Cooper and bringing forward these protocols
7 which have been on your agenda, I guess, since
8 February. Again, pretty straight-forward.
9 There's two regarding a hospital diversion and
10 ambulance redirection and one on the adult and
11 pediatric nerve agent organophosphate poisoning
12 anecdote. I would like to take any questions or
13 comments at this time.
14 MR. WRONSKI: Dr. Kugler, just one
15 question. The sensitivity of the ambulance
16 diversion issue, can you just describe for me
17 how you managed to pull this together in the
18 region and get the hospitals to sit down and
19 talk about it? And there are, certainly, other
20 similar protocols in other regions, but they're
21 always difficult to agree on. And I know this
22 one refers to the Nassau County dispatch center,
23 etcetera, etcetera. But it would be useful, I
24 think, for the group to hear how you

1 orchestrated this, all of you, and Mr. Hassett
2 orchestrated it, too. I'm sure he was spending
3 many nights doing this.
4 DR. KUGLER: Sleepless nights, yes.
5 Those are excellent comments. As you know,
6 Nassau County is a very tight community county
7 with many hospitals and a lot of politics. So,
8 that being said, this type of protocol is always
9 met with significant challenge. The reasoning,
10 rationale, behind developing such a protocol for
11 Nassau County was, really, driven through a
12 Nassau committee of hospital emergency
13 department personnel. This was a subcommittee
14 of the REMAC and REMSCO. And the personnel on
15 both sides of the table felt it would be
16 symmetrical to have a redirection policy and a
17 diversion policy developed at the same time so
18 that while hospital emergency departments can
19 sort of raise the flag and tell medical control,
20 look, we're really receiving a huge influx,
21 surge of patients here, and we need some support
22 from you at a regional level, it was also felt
23 that that could be of use. And as everyone
24 around this table understands, that hospital

1 diversion really only works when it's very well
2 organized. And, unfortunately, once one
3 hospital goes on diversion, it puts a great
4 responsibility on other hospitals, particularly
5 in the neighboring areas. And, again, for those
6 of you who don't know Nassau County, there are
7 really hospitals every several miles. It's not
8 as if it's a rural area. So distress from one
9 hospital going on diversion could absolutely
10 stress another hospital. So, again, it was a
11 very sensitive discussion that took place. It
12 was done so with the input of the hospitals and
13 the hospital administrators. And I believe what
14 came out of it was something that still is met
15 with some consternation by the hospital
16 administration, but with an understanding that
17 as long as, again, there was symmetry -- there
18 were two policies coming forward at once -- that
19 this was something that would not be abused.
20 And I hope I was able to describe it to you.
21 Again, it's not often that a hospital goes on
22 diversion. Obviously, short of structural
23 reasons for diversion -- a failure in power, a
24 failure in a specific diagnostic piece of

1 equipment that may provide definitive diagnostic
2 information -- the issue here is diversion based
3 upon surge of patients and ability to offload
4 EMS ambulance stretchers in an appropriate time
5 frame to provide appropriate care, and that was
6 really the reasoning behind this. Mr. Hassett,
7 do you have any other comments?
8 MR. HASSETT: You stated it well.
9 MR. WRONSKI: Thank you. You know,
10 as I've said in the past, when I first saw this,
11 flags went up in my brain, as a bureaucrat; can
12 we do this? I'd mentioned that to John. I
13 said, you know, there's some question here. I
14 may need to run this by DLA. And then I reread
15 it at least twice, and said, well, I'm not going
16 to run it by DLA. We think we can do this if we
17 all sat down and we review -- as in we in Nassau
18 County -- and work this out and kicked around
19 the pros and cons of it and agreed that this
20 works for our given region. And so I applaud
21 you. I think it's well written. I wanted to
22 understand the process and how you managed to
23 get in and get this done. And it's not that
24 Nassau is a contentious county. It's a very

1 nice county. I visit it often. But any county
2 that has more than one hospital has a difficult
3 time, and you have quite a few hospitals,
4 actually, in Nassau County. So, you know, I
5 applaud you. That is great work.
6 DR. MARSHALL: Thank you. Any
7 other questions for Nassau County? Yes.
8 DR. GOODMAN: What efforts are
9 being made to ensure that the hospitals
10 maximizes its ability to surge and move patients
11 through the system? We know, many of us, as
12 working in hospitals, that there are often
13 barriers to getting patients out of the
14 emergency department. Those barriers are not --
15 are achievable to overcome with some foresight
16 and effort on the part of hospital
17 administration, but we know that that doesn't
18 always occur. What efforts are being made to
19 make sure the throughput is occurring and that
20 this is not simply just let's throw up the white
21 flag, we've given up, even though that we may
22 have beds that are dirty but not yet cleaned;
23 we're not maximizing hallway space; we haven't
24 yet cancelled or deferred elective surgeries.

1 DR. KUGLER: I'll just comment by
2 saying, again, this is no news to anyone around
3 this table that the ills of hospital capacity
4 can be the ills of the emergency department, and
5 I don't think this was done in any capricious
6 manner. And I will tell you that are several
7 CEOs in Nassau County who are quite concerned
8 with the language in this protocol. That being
9 said, the hospitals have been involved with the
10 development of this from the get-go. There is a
11 subcommittee at the REMAC and REMSCO made up of
12 hospital and emergency department folks, as well
13 as hospital administrators. The answer to your
14 question is, what are we doing? We have been
15 doing simultaneous studies on the hospitals so
16 that we understood the difference between
17 reality and hearsay. And what I mean by that,
18 often times EMS feels that their turnaround time
19 in the emergency department is protracted, and
20 we, in fact, measured what the average
21 turnaround time was in all of the emergency
22 departments in Nassau County so that we could
23 communicate back to EMS that they're not, in
24 fact, waiting an inordinate amount of time. I

1 believe the study ranged from a low of 17
2 minutes in one hospital to a high of, maybe, 27
3 or 29 minutes in another hospital. And the null
4 hypothesis to that analysis was that it was
5 upwards of an hour turnaround time. So we're
6 doing a lot to address the ED throughput issue,
7 both from the entry point for EMS, as well as on
8 the back door into the hospital. There is not a
9 hospital in Nassau County that isn't concerned
10 about their market share, and they understand
11 the importance of moving patients through the
12 system and not losing them to other hospitals
13 when they are on diversion. So I appreciate the
14 comments, but I don't think there is anything
15 unique to Nassau County that isn't unique to
16 emergency medicine throughout the State and the
17 United States. So those are the comments.
18 MR. WRONSKI: If I could comment,
19 since you asked what's being done? I was going
20 to bring this up to SEMAC, and I still will, but
21 I'll mention it now. There is a letter dated
22 May 5 signed by James W. Kline, Jr. He's a
23 deputy commissioner, Office of Health Systems
24 Management. It went to all of the CEOs in the

1 hospitals across the State, and it specifically
2 talks about emergency department overcrowding
3 and the many letters that have been sent out
4 over time by Commissioners, but that the
5 Department is moving to another level, and that
6 level is to begin to do a systemwide collection
7 of data and systemwide reviews of hospitals to,
8 specifically, with the intent to determine how
9 they're working with hospital overcrowding, what
10 the solutions of some hospitals are and document
11 the problems and, ultimately, share that with
12 the system and hope to make changes, but a more
13 proactive going into the hospitals to begin this
14 year, on-site focused review of the overcrowding
15 problem. And while the Department certainly had
16 committees that had met and discussed this,
17 looked at literature, they are going to take the
18 next step and formally start to go into
19 hospitals and look at particular issues, both
20 for, you know, where it's not working at all and
21 find solutions in New York that have worked and
22 see if they can be duplicated elsewhere. But,
23 you know, I think that it's just complementary
24 what, you know, Nassau and some other regions

1 and cities are trying to do on their EMS side
2 because they have to work in partnership, but
3 the Department is taking the next step on this.
4 DR. MARSHALL: We could spend weeks
5 discussing what hospitals could do or should do,
6 and I think from the New York City experience,
7 when we put in a hospital redirection policy or
8 protocol for a 911 system, in the hospitals that
9 I'm aware of, the hospital's administrative
10 staff are keenly aware of market share and the
11 benefits of the patients into the hospital by
12 getting patients in and out of the emergency
13 department, so there is a large push on the
14 inpatient side to do that.
15 DR. HENRY: Dr. Kugler, are you
16 going to keep statistics on this and measure
17 this and make it publicly available?
18 DR. KUGLER: Not personally,
19 Dr. Henry, but the --
20 DR. HENRY: Will the program agency
21 then?
22 DR. KUGLER: Yes, the REMAC and
23 REMSCO. I'll let Mr. Hassett answer that
24 question.

1 MR. HASSETT: Part of the procedure
2 indicates at the very end that the facility
3 medical control, which would be the pivotal
4 point for reporting, will provide a monthly
5 report to the regional council office with the
6 number of hours the regional facility goes on
7 diversion or is placed on --
8 DR. HENRY: Then I have a question.
9 You know, you're defining the need for diversion
10 when the hospital's reached its maximal capacity
11 to manage new patients, and you sort of further
12 define it, all the beds are occupied and there's
13 three ambulances waiting 30 minutes and they're
14 still not triaged; that's your definition?
15 DR. KUGLER: Yes, that's the
16 procedural definition.
17 DR. HENRY: So I just -- you know,
18 and this is to Mr. Wronski, too. I mean, at one
19 point New York State law defined when a hospital
20 could go on diversion, and it was for cities
21 over a million, but it said that you would
22 endanger the life of an incoming patient or you
23 would endanger the life of a patient in the ER,
24 and this is a different definition, and I wonder

what the variation is around the State and if there is any definition for diversion that the Department looks at or it's just ad-lilb when whatever hospital wants to come up with.

DR. MARSHALL: Okay, yeah, I think the definition of diversion or what a hospital calls "diversion" hasn't changed. I think what's -- what's new, at least for New York City and it sounds now like Nassau is redirection, and redirecting ambulance is more of an operational issue than a medical issue. If you have three ambulances waiting 30 minutes or more in a hospital emergency department, you're affecting the operations of EMS in that region, and I think that that's -- at least in New York City, that's what part of the issue was -- and Dr. Kaufman can correct me if I'm mistaken, but is to get the ambulances back out there. I mean in my hospital, my ambulance turnaround time over the past year has gone from 27 minutes to 30 minutes. It increased three minutes. I've increased staff. I have more stretchers. I don't have any more space, but even with all of those things and administration aware that it is

in the patient's best interest and the hospital's financial interest to get patients in and out of the ER in a timely fashion, it still becomes more and more difficult. Our volume has gone up, and that's part of the problem, but I think that's, from my point of view, the difference between diversion and redirection.

DR. GOODMAN: Carl Goodman, Suffolk County. The Hospital Preparedness Bureau has published a comprehensive emergency management plan with a very, very nice matrix of their emergency plan activation criteria. One of it is ED length of stay, waits to be seen and capacity. I would just suggest to the committee, although, they're not specifically relative pertaining, you know, with regard to approval of this protocol, that there be a general consideration that when diversion issues are considered, that tying that into activation of their emergency management plan be considered and bringing the recommendations of the comprehensive emergency management plan in line with this committee's actions.

DR. MARSHALL: Dr. Henry.

DR. HENRY: My only other comment in this, it's very topical. I mean it's important to talk about it, and I think we'll talk about it more at the disaster meeting on Wednesday. But, given what some regions have experienced in preparation for a new virus coming in and the respiratory precautions, and the state of ERs, whether there was any change, should mark a lot of concern on our parts, because the most vulnerable patients who could be exposed to new viruses linger in emergency departments with co-morbid conditions, and then they get, you know, contagion and spread it upstairs when they eventually get upstairs. So, to me, it's the ability to manage this when everyone's on alert because there is a new virus out there is a great public health concern.

DR. MARSHALL: Dr. Young.

DR. YOUNG: Yes. Greg Young, State Health. Actually, this probably should be directed at Dr. Kugler and Mr. Hassett. Under your policy section, when talking about when it does not apply, you talked about, obviously, unmanageable airways, things like that, the

patient's route to region and area trauma centers, you need to add to that New York State designated stroke centers because that was made very clear in the designation process. They cannot re-route regardless of their situation. So if you could add that, I'd appreciate it.

DR. MARSHALL: Any other comments about the protocols? In addition to the diversion and redirection, there was also the nerve agent protocol.

DR. DAILEY: Excuse me, just one second. If I could ask Dr. Young just to clarify that because, given the preponderance of hospitals and just the concentration in Nassau County, if a hospital really is that busy, are we going to benefit a stroke patient by not going to another stoke center if it's within the window?

DR. YOUNG: If there's, certainly, a close stroke center two minutes away, medical decision-making enters into it. We're not taking away from that, but we don't want a stroke patient to be diverted to a non-stroke center because the stroke centers have a

1 diversion for strokes. They committed, when we
2 did our designation reviews, that they would be
3 able process those patients the same as a trauma
4 center would, so it's the same sort of model.
5 DR. DAILEY: Okay.
6 DR. MARSHALL: Dr. Kugler and then
7 Mr. Hassett.
8 DR. KUGLER: Go ahead, John. You
9 may have --
10 MR. HASSETT: Yes, what I was going
11 to say is that the reason why it had been
12 omitted is because of all of the hospitals in
13 Nassau are designated stroke centers.
14 DR. YOUNG: Congratulations.
15 MR. HASSETT: And should be a model
16 for the rest of the State.
17 DR. KUGLER: The only other comment
18 I would make to that is that diversionary status
19 really is brought down by the medical control
20 authority and not really just a white flag by a
21 capricious emergency department, so, in fact,
22 there is oversight throughout the entire
23 process.
24 DR. MARSHALL: Any other comments

1 on the Nassau protocols?
2 Move to accept the Nassau protocols.
3 MS. CHIUMENTO: Are you going to
4 discuss the second portion, the organophosphate?
5 DR. MARSHALL: Yes. Do you have
6 any comments on those?
7 MS. CHIUMENTO: Just one, and that
8 is because this is now a new scope -- well, sort
9 of a new scope for BLS, yes, they're allowed to
10 give epi-pens, but that's under a specific law.
11 This would be a new status for them, so I would
12 think that if we are going to do this, we at
13 least have to make sure that the training is in
14 place. I'm sure you do, but I mean just because
15 it is a new item for BLS that is no -- not
16 currently in state protocols, BLS protocols. I
17 think -- what we've done in other cases at the
18 ALS level is that we've allowed them to do it as
19 long as the region guarantees that training is
20 done, and I suspect that we can probably do the
21 same thing with this even though it's at the BLS
22 level. I'd just like to look for that.
23 DR. MARSHALL: Mr. Hassett.
24 MR. HASSETT: Sure. Actually, we

1 made the rush after September 11, 2001 with
2 regards to the threat of WMD; the State issued
3 out a cash of Mark 1 kits to all the OEMs around
4 the State, or the EMS coordinators. And at that
5 time the REMACs had to come up with a protocol
6 for administration of that, which was both at
7 the BLS and ALS levels since they are
8 auto-injectors. And Nassau had come out with
9 that. This is just a revision of it, to take
10 out the Mark 1 reference, and because of the
11 fact that the manufacturer's no longer is
12 producing Mark 1 kits, and as opposed to using
13 another brand name, which is to say we decided
14 to use the auto-injector as a generic name.
15 DR. MARSHALL: Okay, any other
16 comments? All those in favor of accepting the
17 Nassau REMAC protocols, raise your hand.
18 Opposed? Abstained? It carries. Thank you.
19 Mercy Flight. Before we start the
20 discussion on the Mercy Flight protocol, I'd
21 like to introduce Paula Grogan, a program
22 administrator from the Bureau of Narcotics
23 Enforcement Licensing program, and Deborah
24 Hotalling, pharmacy consultant also from BNE.

1 Welcome, and thanks for coming. You're on.
2 MR. DAVIDOFF: Jack Davidoff,
3 Finger Lakes Region. Originally, I had wanted
4 to bring forth a protocol for Mercy Flight
5 specifically that included the use of a drug
6 called ketamine. I was told by the state health
7 department that we couldn't talk about such a
8 protocol until we spoke about the drug itself
9 since we couldn't talk about a protocol that
10 included a drug that was not approved for use in
11 a prehospital setting, which does make some
12 sense, so I guess we should talk about the drug
13 first. And the drug not only, I guess, needs to
14 be approved by the New York State Health
15 Department but also by the Bureau of Controlled
16 Substances, as well. So, let's talk a little
17 bit about ketamine.
18 Ketamine was first introduced in the
19 early 1960s as an alternative to PCP. It's been
20 around for over 45 years. It's been used as a
21 dis-associative anesthetic. It's quite
22 specific. There's nothing else quite like it.
23 It's been used in battle fields and third-world
24 countries as an analgesic. It does have some

1 mild analgesic use, but more so because of its
2 dis-associative properties. It disassociates
3 patients from their pain. It's been used quite
4 extensively in this country for pediatric
5 conscious sedation. And if you go through the
6 literature, there is quite a bit of literature
7 out that that shows its safety profile in the
8 pediatric population. It's quite safe.
9 One of the positive things about
10 ketamine is that when we use certain drugs in
11 the prehospital setting, particularly a drug we
12 used called "Etomidate," there has been some
13 talk and certainly studies to prove that it
14 decreases adrenal synthesis of catecholamines,
15 and that can be a problem in some of our
16 patients; although, we've not really seen this
17 clinically. One of the positives of ketamine is
18 that it increases adrenal synthesis of
19 catecholamines. If you have a patient that has
20 a low heart rate, a low blood pressure,
21 particularly our trauma patients, catecholamines
22 release may increase the heart rate, it may
23 increase the blood pressure, and may help us
24 intubate and maybe bring that patient to a

1 trauma center where they may survive. One of
2 the positives about ketamine, it's a potent
3 broncho dilator for use in patients that are in
4 bronchospasm. I, personally, it's my drug of
5 choice when I want to intubate someone that has
6 bronchospasm. It has a lot of positives.
7 Does it have negatives? Absolutely.
8 There has been some suspicion there may be some
9 neuro toxicity. Certainly, the biggest negative
10 about ketamine is that it's very widely accepted
11 on the streets as a drug of abuse, and
12 apparently it's in quite a high demand; however,
13 there has also been some talk that it might be
14 dangerous in head-injured patients, in cardiac
15 patients. Most of the studies that I've seen
16 tend to disprove that and show it's pretty safe
17 for use in almost any patient. It's been used
18 in many countries by prehospital personnel,
19 people with limited education compared to our
20 own paramedics. It's used by many air medical
21 services in this country with very good success.
22 Patients that are entrapped, patients that have
23 serious injuries, or who are at risk of serious
24 injury, have huge stress levels. I can only

1 imagine what their post-traumatic stress is
2 like. The people that are trying to extricate
3 them. Also, if you're a fire fighter and you're
4 trying to extricate a patient and the patient
5 has significant pain, you go to move them, they
6 scream, you stop, it slows down the extrication
7 process. Ketamine would allow those
8 extrications to be much more efficient.
9 Air medical services today are looking
10 at every possible way of increasing safety and
11 decreasing the risk to crews, patients and
12 equipment. A violent patient in a helicopter is
13 a bad situation. We try to avoid it, but
14 obviously we can't avoid it 100 percent.
15 Ketamine is a rapid-acting sedative. It can be
16 used in the middle of a patient who becomes
17 violent to sedate them quickly and make that
18 situation, which was potentially very dangerous,
19 now a safe situation. Safe for the crew, safe
20 for the helicopter, and safe, most of all,
21 really, for the patient because this a safe
22 drug. It has very little effect on respiratory
23 status, very little effect on human dynamics,
24 but it works quickly. So, therefore, I am

1 bringing forth to this group a discussion on
2 ketamine to be used in the prehospital setting,
3 particularly in the air medical setting for
4 starters, and I won't go any further than that,
5 so I'll open it up for discussion.
6 DR. MARSHALL: Thank you. The
7 floor is open. Do you have any comments, or do
8 you want to sit and listen for a while?
9 MS. GROGAN: Really, we're,
10 essentially, listening to this conversation.
11 Lee Burns came to the Bureau in late April --
12 can you hear me? Sorry. Paula Grogan. Lee
13 Burns came to the Bureau in late April and
14 advised us that this was a discussion that was
15 on the table. So, really, our role today is
16 just to listen to the conversation before we
17 move forward with the position or not move
18 forward with the position. I think your process
19 requires that there is SEMAC approval and then a
20 proposal, or a formal recommendation, to the
21 Health Department. So Lee asked us if we would
22 attend to listen; that's what we're doing. We
23 did bring along Deborah, as the pharmacy
24 consultant. So we're open to listening, and

1 then we can go from there.
2 DR. MARSHALL: Thank you. Dr.
3 Funk.
4 DR. FUNK: I also find ketamine
5 very effective in my own clinical practice. I
6 use it mostly for its broncho dilating and
7 sedating properties. I do subscribe to the
8 belief that it's, probably, not in my mind the
9 best drug or the best sedative to use for
10 patients who have significant cardiac disease
11 because of the catechol surge that has been
12 associated with it, or with head-injured
13 patients, but I find it to be a very reliable,
14 safe medication. It can be given IM, as
15 Dr. Davidoff suggested, and it's very reliable.
16 You know within five minutes of administration
17 of this drug, intramuscularly, your patient is
18 going to be sedate, not moving very much with an
19 intact airway. It does not take away airway
20 reflexes, and in an extrication situation that
21 could be particularly useful. We use it in our
22 emergency department, primarily, for sedation
23 and, you know, for multiple different
24 procedures, and in preparation for intubations

1 of patients with bronchospasm, and sometimes you
2 wind up not having to intubate them because it's
3 got such great broncho-dilatory effects. I
4 don't use it that often, but when I use it, it's
5 the best drug. I also should, probably, say
6 that I'm aware that this drug does exist in the
7 approved controlled substance plan in the State
8 right now. It is not in active use. It's not
9 in the drug bags, but it is a part of the
10 controlled substance plan that has been approved
11 for several years now.
12 MR. WRONSKI: Can I ask a question?
13 One of the things I heard you say is that, you
14 know, it's used by yourself in limited
15 situations you identify, and when you pick those
16 cases correctly, obviously -- and I'm sure you
17 pick them all correctly -- it's the best drug.
18 My question is with prehospital, by paramedics
19 or critical care techs who might use this, what
20 kind of training would they need? Would this be
21 an online medical control issue? And in your
22 view, you know, how often would ketamine be
23 chosen over the other drugs? You know, you
24 know, how critical is the need for the

1 availability of it, and can prehospital
2 determine when it's best to do this?
3 DR. FUNK: I would suggest, in the
4 flight arena, almost all of the medications that
5 are in the protocol or guidelines for the flight
6 teams to use are on standing order because of
7 the situation that they often find themselves
8 in, and this drug would be used emergently. And
9 if medical control were not available, I
10 wouldn't want to take it away from them. From
11 the flight perspective, we've talked at this
12 table a number of times about the amount of
13 training that goes into assuring that these
14 folks are trained to a very high level to take
15 care of very sick patients every single day. I
16 would hesitate to make it a medical control
17 option, at least for flight teams. I know that
18 that's what Dr. Davidoff is discussing, but from
19 the general perspective, I think that it's a
20 safer drug than Etomidate; certainly, a safer
21 drug than succinylcholine. Those drugs have
22 been put on standing orders -- regions. You
23 know, if you can train a paramedic to administer
24 succinylcholine, which has way more

1 contraindications than ketamine does, you can
2 train a paramedic to give ketamine. I would not
3 hesitate.
4 MR. DAVIDOFF: I might add, almost
5 the overwhelming majority of my crews, and I'm
6 sure your crews as well in Albany, have already
7 been trained on this drug. A course is taught
8 in this state, the airway course. Most of the
9 national courses incorporate this drug because
10 it's used elsewhere; it's part of their standard
11 of care. My folks have been ready to use the
12 drug for six or seven years. It is again -- and
13 I guess we're all trying to stress -- an
14 extraordinarily safe drug. There are drugs out
15 there today that we're using every day that are
16 much more dangerous. Morphine, which is carried
17 by, I venture to say, maybe 75, 80 percent of
18 the advanced life support people in the State.
19 It is a very dangerous drug. It creates a lot
20 of allergic reactions, histamine release, and
21 that's forgetting the side effects or the
22 effects that we want -- the sedation, the
23 respiratory depression and so forth. Ketamine
24 is used in countries where they don't have

1 anesthesiologists. It's used by folks that have
2 limited training for the surgical procedures.
3 It's as simple as giving the right dose. It can
4 be given IM. It can be given IV. It can be
5 given intranasally. It can be given almost any
6 route. As long as you correctly dose it, you're
7 going to get the same effect, regardless. What
8 you're not going to have is any problem with
9 respiratory depression. So in the prehospital
10 setting this is almost as ideal a drug as you
11 can find.
12 DR. DAILEY: Dr. Marshall.
13 DR. MARSHALL: Yes, Dr. Dailey.
14 DR. DAILEY: All things being
15 equal, I wish Dr. Davidoff had used calcium
16 chloride as his example of a dangerous drug on
17 board these ambulances rather than morphine.
18 Certainly, narcotics and narcotics enforcement
19 would have given him a little less pause.
20 I, actually, question us sitting here
21 talking about this drug at all because we're
22 making a mistake. We're discussing medical
23 efficacy of a drug that most of the physicians
24 at this table all agree on. As a response

1 physician, one of the first drugs that I request
2 from my pictus (phonetic) when I head out the
3 door is ketamine in large doses because it's a
4 safe drug, and it's something that I want to be
5 able to use to appropriately take care of the
6 patient that I have to extricate from a painful
7 situation. The reason that we're talking about
8 this drug has less to do with its efficacy in
9 care and more to do with our concerns about it
10 being diverted. Our colleagues, who are
11 narcotics enforcement, wouldn't be here at all
12 if there weren't those concerns, I'm sure.
13 They'd allow us to debate something we all agree
14 on, and then they'd go on and probably have
15 better ideas what to do with their day rather
16 than listening to me. But I think we need to
17 address, on a broader range, how we're going to
18 deal with questions of diversion. We have been
19 pussyfooting around the idea of how to use
20 Fentanyl in the field. We have created
21 protocols with the idea that we'll minimize risk
22 of diversion by increasing the chance of loss by
23 using ampules, instead of vials, for Fentanyl,
24 and there are mistakes that we're making in

1 cases of strict patient care. Let's create some
2 systems to assure that the drugs going out with
3 our crews are coming back with our crews, or
4 have been put into our patients, and then let's
5 use drugs that are appropriate for our patients.
6 Let's pass plans, all right, for use of
7 controlled substances in the field that can take
8 the pause and concern, some of the concern, away
9 from narcotics enforcement, all right, and let
10 them recognize that our field providers have
11 more oversight over their use of controlled
12 substance than just about anyone else within the
13 health care community and are safer with those
14 substances than most other folks in the health
15 care community. There isn't an anesthesiologist
16 in the hospital that has the oversight that one
17 of our paramedics does, and our paramedics use
18 so much less medication on a yearly basis. We
19 really need to make sure that we're doing
20 appropriate oversight for what we're using and
21 that we've got safe systems for our providers.
22 So what I'd like to do is just end this,
23 approve ketamine for use in the prehospital
24 setting. I don't think it should be restricted

1 to air services. I think it should be available
2 for ground as well, and I think it should be
3 used within safe and appropriate, well
4 controlled pharmacy administrated controlled
5 substance program.
6 DR. MARSHALL: Thank you,
7 Dr. Dailey. Dr. Broderick.
8 DR. BRODERICK: John Broderick,
9 Mountain Lakes. Mike, I like that idea.
10 Certainly, if we get into that, though, because,
11 specifically, I think ketamine is the drug of
12 choice for extrication. There hasn't been a
13 flight physician previously that clearly fits
14 that particular scenario, but I would be a
15 little concerned that that may be used in other
16 situations where an analgesic may be better. So
17 I would like to think, if we go this route, then
18 certainly we would follow quickly with state
19 standards as to its use. Because, again, I
20 think somebody with a broken femur, yelling and
21 screaming that you may hear with a broken femur,
22 in a vehicle that the roof is crushed in and
23 you're having trouble getting to, ketamine makes
24 perfectly good sense, to get in, maintain that

1 airway so you're not trying to intubate somebody
2 through a side window or anything of that
3 nature. But at the same time, somebody who has
4 been taken out and is still screaming because of
5 their broken femur, is then going to get the
6 narcotics that they need at that point. So I
7 want to make sure we would follow this with some
8 standards so ketamine is not so easily used and
9 taken where analgesics should be more
10 appropriately used in that circumstance.
11 DR. MARSHALL: All the people that
12 have made comments have all made comments in the
13 favor of ketamine in the prehospital setting,
14 and it sounds like Dr. Dailey has made a motion
15 that we move forward with approving ketamine for
16 use in prehospital care, not limited to air
17 medical transport. Is there anybody who has
18 severe or significant objections to the use of
19 ketamine in the prehospital setting from the
20 medical standpoint, understanding all the
21 diversionary issues and safety and security of
22 the patients and the crews?
23 DR. DETRAGLIA: I'm going to have
24 to admit my ignorance of the medication, but

1 this came up in one of our hospitals recently.
2 And the anesthesia department, to a person, said
3 that this drug should never be used. I don't
4 remember the details of that, but with that
5 stuck in my craw, I have some questions, and I
6 will certainly have to learn a lot more about
7 this medication.
8 MR. WRONSKI: Dr. Marshall, to make
9 it simple, one of the things the SEMAC can do
10 right now is simply vote to include it in the
11 drug formulary. There could be a secondary
12 discussion, when you choose, about whether or
13 not this should be widely, quotes, on ground and
14 air. But certainly you can add it to the drug
15 formulary if you believe it's appropriate in
16 prehospital, and we would bring it to BNE for
17 discussion, and the Department can -- but maybe
18 that would be one way to concentrate just on the
19 drug --
20 DR. MARSHALL: Okay. Dr. Dailey,
21 would you mind if we changed your suggestion to
22 just adding ketamine to the state EMS formulary,
23 prehospital formulary, leaving out air versus
24 ground?

1 DR. DAILEY: That sounds like a
2 much more concise version of the exact same
3 thing.
4 DR. MARSHALL: Thank you. Is there
5 a second? I'll assume that that's a motion. Is
6 there a second to the motion? One, two, three
7 four seconds. Any other discussion? Yes.
8 DR. FAIRBANKS: I just want to make
9 sure we leave with a positive reassuring note.
10 I work, most of my clinical time, in our
11 pediatric ED, and it's the preferred drug there.
12 And, nationally, from a pediatric emergency
13 medicine standpoint, ketamine is considered to
14 be one of the best sedation drugs, so I'm not
15 sure what the anesthesiologist was referring to,
16 but it's a nationally accepted standard of care.
17 DR. MARSHALL: Thank you. Do you
18 have any questions for the group? Yes.
19 MS. HOTALLING: Just I hadn't heard
20 it around the table --
21 DR. MARSHALL: State your name.
22 MS. HOTALLING: Yeah, Deborah
23 Hotalling, pharmacy consultant for BNE. One
24 thing I did not hear around the table from a

1 pharmacist's point of view, and I don't have
2 experience with ketamine, or very little, from
3 prior to working for the Department of Health,
4 is that there is no reversal agent currently.
5 Is that any concern with any of the physicians
6 or anesthesiologists in the room --
7 DR. DAILEY: In the settings that
8 we're using it in -- I'm sorry, Doctor. In the
9 settings that we're using it in, we wouldn't
10 want to reverse it, and the effects that you're
11 getting from it aren't ones that you're looking
12 to reverse. It's not like a narcotic where
13 you're getting a significant amount of
14 respiratory depression you may potentially want
15 to reverse. That's not an effect of this drug.
16 DR. FAIRBANKS: I'll add to that.
17 Terry Fairbanks. I'll add to that by saying
18 there is a reversal agent for the most common
19 side effect, and that's Atropine, because the
20 secretions are, really, the biggest issue. And
21 in Mercy Flight, it's in their protocol, which I
22 reviewed. They did compensate for that.
23 DR. MARSHALL: Dr. Funk.
24 DR. FUNK: The one thing that

1 wasn't mentioned, as we discussed the drug,
2 also, is it has a very short duration of action.
3 When it's given IV, it's maybe 10 minutes. When
4 it's given IM, maybe 15, maybe 20 minutes, just
5 from my experience. I don't know what the
6 literature would say, but that's my experience.
7 DR. MARSHALL: Any other questions?
8 Comments? Seeing none, the motion on the floor
9 is to add ketamine to the state EMS formulary.
10 All those in favor, raise your hand. Thank you.
11 All those opposed? Abstained? The motion
12 carries, one abstention. Thank you.
13 Moving right along -- should we take a
14 five-minute break?
15 DR. DAILEY: Actually, can we ask
16 one question from our colleagues before they go
17 to back to Troy?
18 DR. MARSHALL: Yes.
19 DR. DAILEY: The REMO region had
20 written a letter to the Department of Health,
21 which I understand they were in conversation
22 with Narcotics Enforcement. Fentanyl is
23 approved currently for use only in 100 microgram
24 ampules because there has been a significant

1 amount of breakage and there is a potential for
2 danger to my colleagues in the street, opening
3 those ampules for injury. We've asked for
4 approval to use vials instead. I was just
5 wondering how that was proceeding through the
6 process.
7 MS. HOTALLING: Technically, under
8 advisement, we're looking into the availability
9 of the product put in the vial format versus,
10 when it was originally discussed, it was not
11 available in the vials.
12 DR. DAILEY: It has been available
13 in the vials for years.
14 MS. HOTALLING: But in larger --
15 but in larger quantities.
16 DR. DAILEY: No. I apologize, but
17 it's been available in vials, 2 ml, 100
18 microgram vials for years.
19 MS. HOTALLING: Okay.
20 DR. DAILEY: Our pharmacy
21 colleagues actually had to go through a lot of
22 trouble to be able to find ampules.
23 MS. HOTALLING: Okay. Again, it's
24 under advisement, and we are discussing that,

1 your concerns on the ampules versus the vials.
2 DR. DAILEY: Okay, thank you.
3 DR. MARSHALL: Thank you very much
4 for coming. We appreciate your input. One more
5 question, Dr. Davidoff.
6 MR. DAVIDOFF: Also, for our
7 friends at BNE, now that this has gone through,
8 should it go through the SEMAC, which I'm hoping
9 it will, what will be the next step for BNE to
10 take so that it would be a drug that would be
11 available, realistically, for prehospital?
12 MR. WRONSKI: It goes to SEMAC.
13 MS. GROGAN: Yeah, if that's your
14 process, that it goes through SEMAC, then we
15 would be looking for a formal proposal, or some
16 sort of recommendation that outlines the
17 recommendation so that we can review it and make
18 a determination on whether to approve it or not.
19 MR. WRONSKI: And what will happen
20 is, once it's approved through our process, Lee
21 and Andy will write a memorandum to BNE
22 indicating what's occurred; here's the
23 recommendation; here's the general parameters
24 and ask BNE for a sign off on it.

1 MR. DAVIDOFF: Thank you.
2 MR. WRONSKI: Right, and I do
3 apologize. In this case, the Commissioner needs
4 to sign off.
5 DR. MARSHALL: I'd like to take a
6 five-minute -- Mr. Rob Delagi.
7 MR. DELAGI: Actually, sorry for
8 those of you who need to take a break. Just as
9 a matter of order, I think the motion was to add
10 ketamine to the formulary. Do we still need to
11 move on the protocol, or is that pending BNE?
12 MR. BISHOP: The final Commissioner
13 will sign off.
14 MR. DELAGI: Thank you.
15 DR. MARSHALL: Five-minute break.
16 Thank you.
17 (A brief recess was taken.)
18 DR. MARSHALL: Okay, the next item
19 of business is something that has been on the
20 table for a while and that is the Mountain Lakes
21 Region pediatric anaphylaxis protocol. So I
22 would like Dr. Broderick, if you would, just to
23 remind us about the protocol and --
24 DR. BRODERICK: Thank you, Dr.

1 Marshall.
2 DR. MARSHALL: It's been a while.
3 DR. BRODERICK: This protocol came
4 up to this meeting and was approved, actually,
5 this past February. To our new regional
6 director's credit, he realized that we put the
7 cart before the horse and that we hadn't had the
8 appropriate distribution and commentary for you,
9 30 days, as wanted by the state law, to actually
10 make that process and approval official. So we
11 bantered about. We went ahead, and we sent it
12 out to all of our hospitals in our region, CEOs
13 and EDs, and we really got no commentary back
14 whatsoever, and so this protocol is coming to
15 this body again unchanged, the only change
16 being, really, is that we did have that
17 opportunity to have that 30 day commentary
18 period, which we didn't before. So, really,
19 what we're trying to do is do this in a
20 procedurally correct way this time versus the
21 incorrect way that it was presented last time.
22 I don't think there is any protocol distribution
23 that way because this came up recently, but it
24 is the exact same protocol -- we found one

1 spelling error, I should say -- that was present
2 at the February 9 meeting, I believe, and
3 approved February 9 of 2009.
4 DR. MARSHALL: Okay. As a
5 procedural issue, we're going to need to revote
6 on that protocol because it had to go back and
7 go through the process. So, yes, any comments,
8 questions for Dr. Broderick? Seeing none, all
9 of those in favor of approving the Mountain
10 Lakes regional pediatric ananaphylaxis protocol,
11 raise your hand. Thank you. Opposed?
12 Abstained? The motion carries. One abstention.
13 Thank you. The next item on the agenda
14 is what we've been talking about for a while
15 now, state ALS protocol standards guidelines.
16 I'd like to thank Sharon who has done a lot of
17 work in putting together a draft, and I would
18 like you to take a look at the format more so
19 than the specific protocol. It's up on the
20 board, if you didn't receive it by e-mail.
21 These are just some examples of how our state
22 ALS standards/protocols/guidelines might look
23 like with the various levels of providers in the
24 State, allowing for regional options, inclusions

1 or deletions from the protocols. And, Sharon,
2 if you would like to just go through that
3 quickly just to describe each section?
4 MS. CHIUMENTO: Yes. Basically,
5 one of the things, every time we've tried to do
6 ALS protocols in the past, has always come up,
7 particularly, from Mr. Hassett, that, you know,
8 we don't want to write a specific protocol that
9 is a blanket across the State that does not
10 allow for the regions to make modifications. So
11 I came up with the concept that instead of
12 having medical control options, as we've had in
13 the past, why not make it regional options, so
14 the things that everybody does are at the top of
15 the protocol, and then down at the bottom are
16 all of those other drugs that the regions may
17 want to use. I, actually, did a grid of the
18 whole state. I went on line, looked at
19 everybody's protocols for each one of these
20 different entities and added all of those extra
21 drugs that were available in some regions and
22 not in others, on the protocol, in some regions
23 and not in others. To the bottom, there is a
24 regional option. The region could then make the

1 decision as to which level gives that drug and
2 whether they require medical control or not.
3 So, basically, this is just a, for lack of a
4 better word, a Chinese menu of the acceptable
5 treatments at the New York State level that then
6 can be modified by the region. The region,
7 hopefully, we can give electronic copies of
8 this, so if a region wants to just take this and
9 then modify it for their region, they can, or
10 they can just use it as an example and then put
11 it through their own format. So if you'll
12 notice, what we have at the top is just reminder
13 to do the BLS, because one of things that I
14 discovered doing QA for as many years as I did,
15 was that sometimes people forget to do the BLS
16 stuff before they start the ALS. EMT-I, then,
17 the Albuterol, that's pretty much universal, but
18 using the BLS guidelines that permit it locally,
19 because, obviously, it's asthma, COPD or
20 bronchospasm, because there were different
21 titles depending on the region. And then we got
22 into the EMTCCP. Basically, all those things
23 were pretty much allowed across the State except
24 for a few regions didn't carry the Protropin,

1 but there was nothing that said that they
2 couldn't use it. Some regions had the Alu-pens
3 instead of the Albuterol, so we added an "or"
4 there. And then we got down to this level.
5 This was the level where it's no longer in the
6 CC curriculum, but many of the regions did allow
7 their CCs to do that. So if you'll notice, I
8 say it's either physician option, if they do
9 have to have the medical control, or regional
10 option, if the region wants to do the training
11 and allow their CCs to do that. So, again, it
12 gives each region the ability to make the
13 decisions as to how they utilize the protocol in
14 their region. And then down at the bottom,
15 regional options with or without medical
16 control. And then this would be where all those
17 other things that are in some regions, some
18 protocols, not in other protocols, would be.
19 And then at the very bottom then would be the
20 other considerations; so things like, if there
21 was medication for fighting against C-paps or --
22 anxiety, if there's things about making sure
23 that you need to contact medical control, as
24 notify, you know, other protocols that you might

1 want to look at, anything that might be more
2 informational would then go into the gray box.
3 If you'll notice also throughout the entire
4 protocol, any medication that is not currently
5 in the EMT CC curriculum, I do have an asterisk.
6 So any procedure, like C-pap -- let's see if
7 there are any medications here that are not --
8 this one is not so bad. Some of the others were
9 much -- there were a lot more things in other
10 protocols that were not in the CC curriculum.
11 So I just indicated that with an asterisk so
12 that the region knows that if they do adopt that
13 particular treatment or medication in their
14 region that they would then have to make sure
15 that their people are trained to that particular
16 drug or treatment. Okay, does anybody have --
17 DR. MARSHALL: I think that --
18 Sharon, thank you. I think that is a tremendous
19 amount of work even to do one, but Sharon has
20 done more than one, as you can -- we'll make
21 sure that they're distributed so you can look at
22 it in terms of the format for ALS, the statewide
23 ALS protocols, or standards, or guidelines,
24 whatever we're going to call them, once the DLA

1 figures it out.
2 The other issue about state standards
3 that there was some discussion on since the last
4 meeting was whether or not SEMAC and Medical
5 Standards and SEMAC should consider establishing
6 statewide standards such as it's a standard in
7 New York State that all BLS ambulances will have
8 AED, as opposed to a specific protocol. I know
9 Dr. Dailey and I have had that discussion in the
10 past, and standards like that, so it's more of a
11 standard than an actual protocol. Well, that's
12 another way to look at it. I don't know if
13 Dr. Dailey wants to make any comments on that at
14 this time.
15 DR. DAILEY: No, I think the only
16 comment that bears any repetition from that is
17 just how shocked this body was, just about to
18 the person, when we found out there were
19 ambulances in New York State that didn't have
20 AEDs.
21 DR. MARSHALL: Thank you. So
22 that's two ways to look at this statewide
23 standards/protocols/guidelines. Yes.
24 DR. GOODMAN: Does the State issue

1 BLS standards?
2 DR. MARSHALL: There are state
3 protocols, state BLS protocols.
4 DR. GOODMAN: If they can issue
5 state BLS standards, why not ALS standards, or
6 is it specifically spelled out that they can't?
7 DR. MARSHALL: No, they can. They
8 can issue statewide ALS protocols. And then
9 there was some discussion that had come up about
10 the language. Perhaps, Mr. Hassett can bring us
11 back up to date on that, but there was a whole
12 legal discussion about whether it's a standard
13 or a protocol.
14 MR. HASSETT: Right. The BLS
15 protocols, I guess, is a misnomer. I believe
16 every region adopted the statewide BLS protocols
17 as their protocol, so really maybe they should
18 be renamed as BLS standards, but they're adopted
19 by the region to be operational in their region
20 as a protocol. The only thing I'd make a point
21 of with the format that we're using up here that
22 Sharon provided, there is a possibility that we
23 may want to not be as specific as we are when it
24 comes down to the specific dosages of

1 medications, and leave that to the regions to be
2 able to make a determination as to what dosage
3 they want to have their technicians providing.
4 I know we did it in Nassau. We started taking
5 our medical control options and leaving the
6 dosages out and leave that up to the doc at
7 medical control to make the call as to how much
8 they want you to give at a given time, which
9 reduced the amount of bickering back and forth
10 on the radio with dosing.
11 DR. MARSHALL: Yeah. Yeah, with
12 this, what Sharon has put together, those types
13 of comments are the comments that we would like
14 to have. And how should we continue to format
15 this so that it is something that, you know, the
16 entire State could use, if that's what we
17 recommend to SEMAC? So just take a look at it,
18 and any of those comments, please forward them
19 to me or to Sharon or to the officers.
20 MS. CHIUMENTO: Also, John, to
21 address that, most of the time I've got ranges.
22 If there did seem to be variations, I put ranges
23 in. So we can either put ranges in or not put
24 in any doses at all. I mean that's -- I mean I

1 think that is something we need to decide.
2 DR. KUGLER: I think we should have
3 the doses there. This is a reference document,
4 and, again, I think the regions should do their
5 own. I think this is an excellent document to
6 have the ranges.
7 DR. MARSHALL: Yes.
8 DR. COOLEY: Craig Cooley from the
9 Western region. I would just like to reiterate
10 that this is a wonderful, large amount of work,
11 obviously, and I think it would be a great
12 guideline. I know I'm hoping to take this back
13 and work this into what we have as regional
14 variations. But to know, kind of, where
15 everyone's, at least, theoretically starting
16 from, and over time it would be interesting to
17 see how this works into, potentially, fewer and
18 fewer options, not because we're being told to
19 by the State, but we're just communicating with
20 the different regions and getting kind of a
21 standard so that our providers that transfer
22 from different parts of the State have to not
23 only learn all new medications, which is
24 somewhat understandable, but also just a

1 completely different format.
2 DR. MARSHALL: Yes. Dr. Broderick.
3 DR. BRODERICK: John Broderick,
4 Mountain Lakes. Yeah, I'd like to commend you
5 on the work, as well. I'd like to look at this,
6 and, again, the nomenclature may have to be
7 decided, but, I would agree, as a guideline.
8 The idea is that this is something that gives
9 guidance to local REMACs, I think, is very
10 helpful. Just a bit of a word of caution in
11 regards to having a -- if we're going to think
12 about having a statewide protocol, which I
13 understand from an overall philosophy in that
14 the medical literature and a body of knowledge
15 doesn't change from Upstate to Downstate to
16 Western New York, and I would agree with that
17 100 percent, but I think the practice variations
18 in each region need to be considered, in that,
19 let's just say we went through to a -- in some
20 of the commentary why we should have a state
21 protocol so then the docs can really focus more
22 on QA. All right, I get that, in some of the --
23 less of the protocol nuances. But I would say
24 -- let's say this argument with ketamine, if

1 that was brought in and then some agencies could
2 just take that from the State and begin to use
3 that, and they would -- the training wasn't
4 there or the necessity wasn't there to use that
5 medication, then that QA process, we could --
6 then become more of a hammer in trying to say,
7 down, you cannot use that, and that would be
8 against our region and we shouldn't be
9 standardized for that. So just a word of
10 caution, to let's keep this as a guideline so
11 that each region can use variations of this and
12 then come to this body. And if there is
13 something they want to use that is new or novel,
14 not on here, make that argument.
15 MS. CHIUMENTO: Exactly.
16 DR. BRODERICK: And I think that's
17 really -- this provides a nice overall guideline
18 of what you did in that schematic of putting
19 everything down in the State, and this seems to
20 really reflect that. And I like the format,
21 too. The format is easy. And I like the idea
22 of one tech over different parts of the State
23 can then have an idea that the look and
24 everything is not going to be different, and

1 they can just concentrate on the protocols,
2 themselves, and the wishes of that -- and
3 medical practice of that region.
4 MS. CHIUMENTO: Commenting on your
5 comment there, one of my proposals would be that
6 then, if a region did make some modifications
7 within the protocol, as long as it was within
8 the documents someplace, they wouldn't have to
9 bring it back. But if they added a new drug or
10 procedure or they went totally outside of the
11 dosage range, whatever we decide is a dosage
12 range, then they would have to bring it back for
13 that reason. And then we could then modify this
14 document very easily to add, for instance,
15 ketamine to the pain protocol here. So, you
16 know, I did take that into consideration. I do
17 want it to be more of a set of approved things
18 rather than a --
19 DR. BRODERICK: I still think this
20 body should see -- I just state kind of an
21 opt-in, opt-out argument. I think if you just
22 opt in and say I'm accepting this and then
23 wouldn't have to come forward here, I think that
24 would be problematic. I think what we certainly

1 could do is, if people are going to go outside
2 the recommendations or, you know, whatever you
3 call it, then they would have to make notations
4 of that. Then anyone reviewing the protocols
5 would know immediately of where they're going
6 outside the recommendations that have been put
7 forth by the SEMAC, and so you can focus on that
8 to, maybe, supportive literature in regards to
9 why you're going outside the guideline or
10 recommendations. But I would still argue that
11 everything that should come here, maybe in a
12 format that would be easier approved. I opted
13 in. I'm not going outside the guidelines
14 whatsoever, and, therefore, you can quickly go
15 through and approval would be from there.
16 DR. MARSHALL: Yes, Dr. Leinhart.
17 DR. LEINHART: Yeah, there's one
18 glaring sort of item that shows up when Sharon
19 did what she did, which is that there are
20 protocols throughout the State that authorize
21 critical cares to do procedures, skills, use
22 drugs that is not part of their training. And
23 so the question in my mind is should the SEMAC
24 adopt standards that say no one will practice

1 outside the scope of their training?
2 DR. BRODERICK: Would that be
3 without any additional training? Because, in
4 our region, an example with C-pap, we put
5 additional training requirements into that as
6 part of an overall airway management and then
7 using C-pap for those agencies that wish to use
8 it, because a lot of ours are still critical
9 care heavy. We are trying to push some
10 educational programs and get more paramedic
11 programs in our region, but right now we have
12 that limitation, unfortunately.
13 MR. BISHOP: If I could just
14 interject one thing. We do require, at this
15 level, if a region wants to have a procedure
16 brought down to the critical care level, that
17 protocol has to be approved along with an
18 educational component; for example, C-pap was
19 approved pretty much statewide. And if a region
20 wanted to use it at the critical care level, we
21 adopted that curriculum for the paramedic
22 curriculum, and they could go forth and use it.
23 So that ability is there, because we did find
24 out that some regions were adding critical cares

1 to procedures and use medications that were not
2 in their training, and that's what we're trying
3 to prevent by having a more standardized
4 protocol, standard whatever you want to call it.
5 And the other thing is we just want to realize
6 that -- I guess Mr. Wronski spoke earlier about
7 what's going on with DLA -- we have to assure
8 that all of these standards that we come up with
9 do have some type of regional variation but are
10 enforceable in an action and in the court system
11 if a medic does not abide by them. And that's
12 what we have to be very, very careful of. I
13 think once DLA's TAG comes out with some final
14 decisions, we'll know much better which
15 direction to go from here.
16 DR. LEINHART: Just as a practical
17 issue, I would say that when you create
18 waivers -- it doesn't matter what kind of
19 waivers, waivers for critical cares -- to do a
20 procedure that was not part of their original
21 training, it raises a question of other medical
22 directors and online medical control physicians
23 not knowing whether this particular individual
24 within that squad has been so trained. So you

1 may impart knowledge to a group of people who
2 represent a portion or all of the squad. Six
3 months later, you have new personnel. To whom
4 does that training pertain? Where is their
5 C-pap badge that tells me that they have that
6 training? I think that's the danger of
7 unlimited waivers.
8 MR. BISHOP: As I say, I totally
9 agree with that. Unfortunately, prehospital
10 care and medicine is advancing much more rapidly
11 than the curriculums are, and that's been very
12 difficult for EMS, but I do totally agree that,
13 by doing patchwork in some regions, maybe down
14 at the agency level, can be very dangerous.
15 MR. ZEEK: I think we should be
16 careful in limiting what critical cares can do,
17 or paramedics, for that matter, in the
18 commercial community and interfacility transfer
19 arena because that would really limit what
20 commercial services are able to do with critical
21 cares because we can't get enough paramedics.
22 DR. MARSHALL: Any other comments?
23 All right, so take this back, look at it. If
24 you have other suggestions, please forward them

1 on to us so we can look at them. Yeah,
2 Dr. Cooley.
3 DR. COOLEY: Just simply, can we
4 make sure this gets distributed because I don't
5 think some of us have received this yet.
6 DR. MARSHALL: Yeah, we'll make
7 sure it gets out. Yeah, we'll make sure --
8 MS. CHIUMENTO: It was e-mailed
9 out.
10 DR. MARSHALL: Yeah, we'll send it
11 again. We can send it again. Again, Sharon,
12 thanks. That's a tremendous amount of work.
13 MS. CHIUMENTO: I'll continue
14 working over the summer based on the comments I
15 get from folks.
16 DR. MARSHALL: Okay. A couple
17 other items. One is the blood bank issue and
18 administering blood products. They have been
19 working on the forms. We do have very rough
20 draft forms. I would ask that, if anybody wants
21 to see them, to see Andrew after the meeting.
22 MS. CHIUMENTO: Actually, Lee has
23 them here.
24 DR. MARSHALL: Maybe you want to

1 put them up? They're very rough, so you can
2 just put them up, look at them and then take
3 them off. Okay, yeah, we can go off the record
4 for this.
5 (Discussion was held off the record.)
6 DR. HENRY: I ask that we look at
7 these because, if you remember our last meeting,
8 we discussed the transfusion and what was coming
9 forward, and we didn't have the details on who
10 was going to be the director, transfusion
11 director, or the squad director, and we have a
12 chance to get some input now.
13 (Discussion was held off the record.)
14 DR. MARSHALL: Two other things;
15 one is, quickly, we talked about epi-pens.
16 There was some discussion about epi-pen
17 legislation and what happened in New York City
18 where New York City REMAC voted to require
19 epi-pens on all ambulances, including all BLS
20 ambulances, and to make it mandatory, not
21 optional, and then to move it forward eventually
22 so that the BLS provider can administer epi in
23 certain situations of anaphylaxis. That was
24 done. Most of the docs in the New York City

1 REMAC did agree with that. It kind of moved
2 forward pretty quickly. We had a meeting with
3 the New York City council. The New York City
4 council was proposing to put forth a city
5 council rule requiring BLS ambulances to carry
6 epi-pens. And since the city council doesn't
7 have any authority over EMS, we stepped in to
8 take care of that. All of the docs did agree
9 that epi-pens should be present on the BLS
10 ambulances; although, there was some dissent,
11 you know, among whether it should be for all 911
12 -- all ambulances participating in the 911
13 system, not the volunteers and the proprietary
14 services that may not have a large need for that
15 particular drug, but it was approved. I don't
16 know if you wanted to make any other comments
17 about the existing --
18 MR. WRONSKI: Yeah. This actually
19 took up a fair amount of time of myself and the
20 staff for one particular week recently when this
21 issue came up. There is a bill that has not
22 been approved, but it has been written and is
23 under consideration in the assembly to mandate
24 epi be carried on all ambulances. And I was

1 asked at one point to put together pilot
2 proposals for epi-pen use in just the city and
3 what would it cost for the system if we did this
4 statewide, etcetera, etcetera. So we went
5 through quite a bit of information and data.
6 That was when I discovered that New York City
7 had actually, you know, had these conversations
8 locally and went ahead and mandated it. I had
9 conversations with the legislature, a
10 legislative member who wrote the bill. And my
11 recommendation to her was that there is an
12 ability through the State EMS council and the
13 SEMAC to have epi-pens in a given region on all
14 ambulances, and that we don't necessarily need a
15 law to do that, and it may not even be needed in
16 many areas because each region has a different
17 -- they all use epi, and they all have
18 anaphylactic shock. Whether they need it on
19 every ambulance is a discussion, I think. And
20 so from my own personal basis, I didn't support
21 the absolute need on every single ambulance, but
22 I want it in every single system, and I want an
23 umbrella there so you know it was available in
24 the 911 system. And I will tell you, for the

1 record, that I recommended that, if you wanted
2 to push something, to make sure that you had a
3 better response in the system, not just through
4 epi but other things, is that you mandate that
5 dispatch centers have EMD, and that they are
6 cognizant of regional protocols and they include
7 them within their EMD protocols regionally. I
8 said write a bill that says that, and that was
9 my recommendation, and I've made that
10 recommendation before to others. I'll stay
11 tuned to see if I get older before it happens.
12 But it's out there. It's under consideration.
13 You should know that. You know, you should give
14 your opinion. In fact, the legislative member
15 was interested in what does the SEMAC and the
16 State council think about something like this.
17 So at this point it's in your court, and there
18 is a bill out there; although, it hasn't passed.
19 It hasn't been put up for vote at this point.
20 DR. MARSHALL: Dr. Dailey and then
21 Dr. Henry.
22 DR. DAILEY: If I may, while we're
23 on the subject of random auto-injector
24 distributions, probably, about a year ago, the

1 Department was nice enough to give out
2 auto-injectors throughout the State which had a
3 nine-month expiration date. To the best of my
4 knowledge, they have never been used. To the
5 best of my knowledge, the drugs that were
6 replaced had never been used. And as a
7 mechanism for terrorism in New York State, the
8 organophosphates that we're expecting, or the
9 nerve agents that we're potentially expecting
10 have not been deployed throughout the world
11 during this period of time. On the other hand,
12 we have now seen pandemic flu. The potential
13 for other bio-agents throughout New York State
14 does exist, and we don't have a mechanism for
15 bio surveillance and a single ability to review
16 records of EMS patients transported in New York
17 State. Before we hand out our next
18 multi-million dollar distribution of
19 auto-injectors that will, once again, contribute
20 to the groundwater supply of Atropine in New
21 State, is there a way for us to redirect these
22 funds to something that, perhaps, might bear
23 more use on a day-to-day basis for the
24 Department of Health and, hopefully, for the

1 rest of the State?
2 MR. WRONSKI: The short answer is
3 no.
4 DR. DAILEY: Okay, thanks.
5 MR. WRONSKI: We'd like to be
6 polite and recognize the reality of what you've
7 said, at least in the part that it's not been
8 used. The epi-pen -- not the epi-pens. The
9 Atro-pens have been purchased and are available,
10 and are -- as of about two days ago, calls are
11 being made to the different counties to
12 redistribute, so that's already done. It didn't
13 cost money, but it did cost, I believe, a couple
14 hundred thousand, but they are, in fact, being
15 redistributed, or in the process of it. In
16 regard to the other things, you know, in
17 identifying funding for, I guess, epi-pens or
18 better data collection reports, I fully agree
19 with that. What I can tell you, though, is that
20 funding that's identified for these other items,
21 it's been fully expected, both in this country
22 and in other countries, that you may not use it.
23 And the argument's been made by those who vote
24 for the funding, right? -- it's Congress -- that

1 it might be needed in a catastrophe once, and we
2 don't know where that's going to be. We've
3 identified risk areas, and so we're going to
4 supply certain drugs and certain training,
5 etcetera, because that could happen, and that's
6 the concept right now. I won't comment as to
7 whether I agree with it or not in the manner in
8 which it's done. Everybody has disagreements on
9 how we prepared and have their own alternative
10 methods, but I can tell you that I have
11 absolutely no ability to modify the use of those
12 specific funds for other types of equipment that
13 aren't directly, you know, aimed at disaster
14 preparedness, and I'm only given limited access
15 to them at times. You know, my input into how
16 to use them or when I've been offered to have a
17 say in this has been very limited, but that
18 doesn't mean that, you know, this body shouldn't
19 speak up and say, listen, you know, we're
20 spending a 100 million dollars or 200 million or
21 a billion -- actually, we get to that figure
22 when we look at the country -- on disaster
23 preparedness; maybe it's better, you know, I'll
24 put my neck out because I've said it in private

1 to my bosses, and my boss' boss before that,
2 that it would be better to spend a billion
3 dollars in this country to restructure, and in
4 some cases not restructure, just rebuild the
5 basic aspects of our health care system so it
6 functions better day-to-day, because I saw, from
7 a pre-disaster I've been part of on a state
8 level, it worked when the local system had a
9 good infrastructure. And a perfect example of
10 that is what happened in, you know, Louisiana,
11 Mississippi, etcetera, during the floods. They
12 had a poor infrastructure. It wasn't that they
13 didn't have disaster preparedness kits,
14 etcetera, etcetera. They didn't have a good
15 infrastructure to deal with their day-to-day
16 health problems or emergencies. When you have a
17 good infrastructure at the local level, it
18 builds up so that at the state level is very
19 strong, because we depend on your local
20 structure. So I'd love to see the monies
21 redirected in a manner that just rebuilds what
22 you work with every day, and then I think you'll
23 be able to take care of the disasters, which is
24 the planning effort. But, you know, that's,

1 again, your committee; the disaster preparedness
2 committee is going to spend about three hours,
3 or so, Wednesday afternoon. I suggest that we
4 put on their table, as one of the other things
5 to talk about and make recommendations. A
6 letter was sent to the Commissioner a while ago
7 pointing out some specifics, but, you know,
8 maybe you need to provide, through that
9 committee, other recommendations, more broad on
10 how you see things. I don't, in a large part,
11 disagree with it.
12 DR. MARSHALL: Dr. Young.
13 DR. YOUNG: If I could just comment
14 on Dr. Dailey's comments on the surveillance
15 side, which obviously is critical. The
16 Department has in place -- I think all of you
17 probably know that -- an emergency department
18 electronic surveillance system. It's called
19 "EDSS." It's been in place now for a year. All
20 hospitals are participating, all of your EDs.
21 And we get data in, and we break it down into a
22 number of categories: Respiratory, neurologic,
23 gastrointestinal, etcetera. And it's based on
24 the patient's chief complaint, not the final

1 diagnosis, because the CDC system is based on
2 the DRGs, and we know that is flawed. We couple
3 that with data from the pharmacy, so during our
4 Swine flu work, which we've gotten very much
5 involved in in the last couple of months, we've
6 been able to track and see. We've watched the
7 transfer antivirals, antipyretics, etcetera, so
8 we have all the Medicaid prescriptions we used
9 to have, eighty percent of the public
10 pharmacies, which we got from Maryland, but
11 unfortunately, due to financial reasons, we no
12 longer have access to that part of the data. So
13 we do have a basic system in place, and we are
14 seeing things that mirror what is going on.
15 Based on the Swine flu, we can't say that we saw
16 a blip that told us it was coming, but, at
17 least, we do have some basic surveillance in
18 now. It's just at a basic level, but I think
19 the Department is moving ahead on that side, as
20 well.
21 DR. MARSHALL: Thank you.
22 DR. HENRY: I'm just curious about
23 this legislation because it was 99 when the
24 legislation was signed for camps and basic EMTs

1 to give epinephrine in New York State. How many
2 regions carry epinephrine in the ambulances and
3 BLS units? Do regions do that? So there is
4 one, two -- so a lot of people already. So what
5 is the need for this legislation --
6 MR. WRONSKI: Unless I told them it
7 wasn't. And I did provide some of that. We
8 reached out to a number of the regions and asked
9 for some data, and we looked at our own
10 databases. So we think there's a fairly good
11 coverage. It's not 100 percent, but we believe,
12 at least from a 911 perspective, that there is
13 excellent coverage.
14 DR. HENRY: Because, you know, when
15 we look back on -- when that legislation
16 happened, that was the bait here, and we reached
17 out for actual cases, and we found cases from
18 parts of the Department who dealt with camps,
19 and there was a cook who ate something in a
20 rural camp, and there was peanut oil in there,
21 and he didn't know it. The cook didn't know
22 that it contained peanut oil, so he died; he was
23 in his 20s. And there was that young girl on a
24 night out with her friends who went to the

1 supermarket, and the mix there had some peanut
2 oil in it, the snack mix, and she didn't have --
3 the unit, the ambulance that came didn't have
4 it, and she died. So we have actual cases. We
5 have a case where a guy was at a bachelor party
6 and he got allergic and he stopped at a fire
7 house because he just made the logical
8 assumption that an ambulance would have
9 epinephrine, and it didn't, and he died. So I
10 think it's logical that the public would think
11 that an ambulance would carry something for
12 ananaphylaxis, so if they don't have it, I would
13 support that, because that's a reasonable
14 assumption a layperson would make that you would
15 seek a treatment from 911, if someone had
16 anaphylaxis. Not to have the medication seems
17 amiss. And I know it's getting more expensive
18 now, the epi-pens. They're like a $100 for
19 epinephrine the way they're packaged, right?
20 MR. ZEEK: Eighty-three dollars is
21 what I found the other day, and that's in one
22 catalogue. But, yeah, they're not cheap.
23 MR. WRONSKI: There is only one
24 manufacturer.

1 DR. HENRY: Well, they turn yellow
2 when they go bad. They look bad when they get
3 old. They may not be bad. They just turn
4 yellow.
5 MR. ZEEK: Yeah, they outdate at 12
6 or 18 months, I think.
7 DR. MARSHALL: Mr. Hassett.
8 MR. HASSETT: Yeah, just on the
9 epi-pen issue, I think the reason why it's still
10 a hopscotch around the State is because of the
11 requirement that the agencies have to have an
12 emergency health care provider and an agreement
13 with the emergency health care provider in order
14 for them to be able to carry the epi-pens. That
15 creates that hopscotch. And they still can go
16 to a fire department or a volunteer ambulance
17 for it and not find an epi-pen, if the agency
18 was not able to get their medical director to
19 agree to sign off on mutual aid.
20 MR. ZEEK: But, on the other hand,
21 most ALS ambulances probably have enough
22 epinephrine on board for cardiac cases to keep
23 whole neighborhoods awake.
24 MR. WRONSKI: Well, that was one of

1 the arguments I made. First, ALS coverage has
2 gotten a lot better across the State, and all
3 ALS has epinephrine, although, not necessarily
4 in -- but it's the same drug, it works. And I
5 don't believe the legislative member understood
6 that, so that modified the thought. But it's
7 still there. It's still on the books. It's on
8 the legislative calendar.
9 DR. DAILEY: If I may? The only
10 other just follow-up to my question on the
11 Atropine auto-injectors, Mr. Wronski, if you
12 would, the one thing that I have heard from
13 members of the Department that concerned me was
14 that we will giving out new Atropine injectors,
15 and you will have to figure out what to do with
16 the old ones was the commentary that had come
17 back to some of the agencies.
18 MR. WRONSKI: Just to be clear, the
19 agencies --
20 DR. DAILEY: Collecting expired
21 ones?
22 MR. WRONSKI: No, we will not. We
23 told agencies -- this was a voluntary issue. We
24 told agencies up front, you don't have to play.

1 Here's the drug. You need to get rid of it like
2 you would other drugs in the system. That was
3 right up front in the training, so they need to
4 get rid of it as they would normally get rid of
5 it. But that was very clearly contained in the
6 training. And, again, it was, you know, up to
7 the agencies whether they were going to
8 participate.
9 DR. MARSHALL: All right, thank
10 you. Stay tuned for more on epi-pens in New
11 York State.
12 The last item that I have on the agenda
13 is the issue of medical direction, online
14 medical control. And just to remind everybody,
15 we did see several -- two surveys, actually,
16 about online medical control in New York State,
17 and one involved -- one was pediatric specific;
18 the other looked at rural hospitals and the
19 availability of online medical control by a
20 physician. And I think when we came to find
21 out, or learn, for those of who did not know, is
22 that online medical control was being provided
23 by people other than the providers, other than
24 physicians in the State. That includes

1 physician assistants, nurse practitioners,
2 perhaps an EMT paramedic with additional
3 training, whatever that term means. And in
4 looking at the regulation, which says that
5 online medical control may be provided under the
6 direction of a physician versus our advisory in
7 9501, which says online medical control must be
8 provided by a physician, so we have to address
9 that incongruity and figure out something that
10 is going to work. We did have a conference call
11 a couple of weeks ago and looked at national
12 standards on medical direction. I think on the
13 conference call, general recognition was that
14 medical direction or a medical director of a
15 service should be a physician always. The
16 question of who's providing online medical
17 control became more an issue, discussed a little
18 bit more in terms of some people felt that as
19 long as a physician assistant had access to a
20 physician by phone immediately that that
21 physician assistant -- or I'll use mid-level
22 practitioner, because I include nurse
23 practitioners in that, also -- could provide
24 online medical control if no physician was

1 immediately available to do. So those are some
2 of the things we came up with on the conference
3 call.
4 Another issue was that it's really not a
5 rural versus urban issue. Yes, there are more
6 instances of a physician not being available in
7 a rural setting or a critical access hospital,
8 but it could also apply to a non-rural area, so
9 we wanted to try to keep the discussion so that
10 it's more general than rural versus urban.
11 There was also some discussion of a
12 couple of cases where, you know, PAs, who were
13 providing online medical control made errors in
14 judgment and a physician was not available in
15 those instances. I don't know what the outcome
16 of the patient's care was, but certainly the
17 number of times online medical control was
18 provided in the State, I'm sure that there are
19 lots of things that we don't know about or don't
20 hear about in terms of adverse outcomes or
21 errors in judgment whether it's made by a
22 physician, or a P.A., or nurse practitioner
23 under the direction of a physician.
24 So the discussion also included whether

1 or not that we should have a medical director's
2 course and who that course would apply to, and I
3 think that that had come up in the past, so
4 that's where we are. We're nowhere. The only
5 agreement that I think everybody was in
6 agreement on was that the medical director of a
7 service, the person who's doing the offline
8 policy, has to be a physician. And we need to
9 discuss, or have more discussion, whether it's
10 here or small groups, about who's going to
11 actually be providing online medical control.
12 Who's on the phone with the paramedic in the
13 field? Who's providing medical direction,
14 whether it's under standing orders or medical
15 control options? Because if it's some P.A.
16 giving medical control, then they could give
17 medical control options. So those are some of
18 the things that we should consider. So I'll
19 open the floor to further discussion.
20 Dr. Cooley.
21 DR. COOLEY: I'd, actually, like to
22 begin with a question since I'm not as familiar
23 with the process in New York State as others.
24 Since we, apparently, are currently in

1 disagreement with Article 30, which is Public
2 Health law, and were we to going forward and
3 say, we think it must be a physician, what would
4 be the process and the timeline and what would
5 be required for this to change? Because my
6 understanding is everything reverts ultimately
7 back to Article 30, if there is ever
8 disagreement.
9 MR. WRONSKI: Well, again, it
10 depends how much you -- it depends what you say,
11 all right? Because what you might say is here's
12 our recommendation for what "under the direction
13 of a physician" means, as you as a group
14 physicians. Depending how you say it and
15 whether you give it as guidance or a mandate,
16 you probably don't have to change anything in
17 the law, but you can affect practice. But if
18 you say that medical direction must be given by
19 a physician, and we really want to stick to
20 that, all right, directly by a physician, then
21 that, to my thinking, would require a change in
22 the law itself, and that would require the
23 Department to decide whether it wanted to
24 support a legislative change and make a proposal

1 to put that in as a change of law. The easier
2 way to go, if you want to be more directive on
3 this over time on, specifically, interpreting
4 what "under the direction of a physician" means
5 is, first, give some guidance and then,
6 secondarily, if you come to a good consensus,
7 you can make a recommendation to the
8 Commissioner and then produce regulations that
9 define what that section of law means. Because
10 that's, actually, what regulations do. They
11 pretty much look at a statute which says you can
12 do the following, and the reg gives more detail
13 to that. So if you need a reg, you can make
14 that decision down the road. I think first,
15 though, is we're all going to have to decide
16 what is the consensus opinion here? And but the
17 timeline a reg will take, if everything works
18 smoothly, a little more than a year, but my
19 general experience has been two years. But if
20 you all agreed on a simple, you know, a couple
21 of sentences that weren't too controversial, you
22 could probably get it out into a reg process in
23 a year, a little bit more than a year. A
24 statute, we've seen statutes pass in a

1 nano-second, but statutes usually take a little
2 time because it has to come up, get the interest
3 of the legislature. They have to see it's
4 important. Go through the process. That can
5 take -- that can be quick. That could be very
6 long. You know, regs are a little different. A
7 year to two years is the window. My suggestion,
8 come to some kind of general consensus, put out
9 some guidance or a policy on this. As long as
10 it's not in direct conflict with generalized
11 language of law, it will fly. So does that
12 help?
13 DR. COOLEY: It does, and I was
14 going to say, based on that, I hope that we keep
15 that in mind before we get too far into the
16 weeds and don't get a year into this and realize
17 what we're trying to do maybe can't be done.
18 DR. MARSHALL: Just a reminder that
19 our current SEMAC advisory requires a physician.
20 So 9501, in fact, then we said it had to be a
21 doctor. So comments? Dr. Broderick.
22 DR. BRODERICK: Yeah, I think the
23 language that we do for online medical control
24 should be, probably, consistent with the

1 language that we use in the State under Public
2 Health Law for smaller volumes -- we won't call
3 them rural versus urban -- smaller volume
4 emergency departments, which allow physician
5 extenders to staff that will direct immediate
6 medical back up. And, so largely that's what we
7 do in our region, is they provide online medical
8 control; that being the physician extenders
9 because they're largely going to be the first
10 people receiving those people in the hospital,
11 but they always have direct and immediate
12 medical back-up either by phone or physically,
13 if that person -- if physician needs to be
14 present in the ED. So to keep the language
15 consistent, the practical implication of doing
16 it otherwise, so the SEMAC advisory would be
17 another hospital to provide online medical
18 control, subsequently, call the ED that's
19 receiving a patient of what they suggested, then
20 not having the physician extender, or even a
21 physician, immediately available to know what
22 that decision was made in the field and why.
23 So, practically, it doesn't make sense. I think
24 we have to be consistent, in that if we're going

1 to allow physician extenders to continue to
2 staff EDs, then we need to have them be able to
3 provide online medical control as long as it has
4 the same provision that there is direct,
5 immediate, medical back-up. That's what I think
6 is important to have.
7 DR. MARSHALL: Can I just ask a
8 quick question? And then there are some
9 comments. Why? I mean just because we allow a
10 P.A. to work in a low volume emergency
11 department where they may or may not have
12 specific training in emergency medicine, why
13 would we want to allow that mid-level provider
14 to provide online medical control in a system
15 that they probably know even less about than
16 they might know emergency medicine? It's just a
17 --
18 DR. BRODERICK: Well, it's a fair
19 question, but it assumes that the person is just
20 put out there without no additional training or
21 the ability to know emergency medicine or
22 regional protocols. In our region, each
23 individual has to know regional protocols,
24 online testing as well with questions about --

1 directed to the specific protocols to be able to
2 provide online medical control; not really
3 terribly different from a lot of other regions.
4 The reason why is because largely it's -- it's
5 already in Public Health Law and already being
6 done that if you're going to have -- to me,
7 logically, if you're going to have a patient be
8 accepted from an ambulance and then be able to
9 take that care from your paramedics or critical
10 cares onward further in the ED and then
11 ultimately, you know, to be admitted and a
12 physician get involved, but to be a bridge, then
13 part of that bridge needs to be the discussion
14 with the EMT in the field about what is
15 happening so you have a better idea as to what
16 is coming. Otherwise, you're going to have the
17 EMT make two calls, in all honesty. You're
18 going to have to do online medical control, but
19 for good patient care, they need to call the
20 hospital as well: This is the patient that we
21 have. This is what we've done. And so the
22 hospital is then able to better respond to the
23 -- I think that creates a lot more work for the
24 EMTs, and a strong poll of my EMTs in the area

1 is that they are very confident with the medical
2 direction provided by the PAs and, you know, the
3 physicians as well, and they feel that to make
4 those two separate calls and to just join the
5 system would not be good patient care.
6 DR. MARSHALL: Over here, and then
7 we'll just come right up the line.
8 DR. GOODMAN: It seems like a very
9 expensive option to use mid-level practitioners
10 to provide online medical control when the
11 physician needs to be readily available. I
12 think there are other options. Other systems
13 use paramedics to be that initial call taker and
14 then, in fact, those speak with physicians. You
15 know, my observations, and it may be different
16 elsewhere, is that mid-level practitioners are
17 not taking care of critical patients, patients
18 in acute pulmonary edema, patients with STEMIs,
19 hypotensive patients in stock. And why would we
20 have them be providing medical control to other,
21 you know, paramedics? It may be much more
22 comfortable treating these types of patient in
23 their initial setting than they would otherwise.
24 DR. MARSHALL: Well, I think that,

1 depending on where they might be, that they
2 might be taking care of those patients. And
3 especially if they're the only provider in the
4 ER, they will be taking care of more patients.
5 MR. ZEEK: They are in rural areas.
6 DR. MARSHALL: Yes, absolutely.
7 We'll start over here and work our way up.
8 DR. TAKATS: Joe Takats from
9 Western region. We have two hospitals in our
10 region where during certain hours mid-levels are
11 the only health care provider in the hospital
12 receiving ambulances. And also in our region we
13 have a bay station course that is designed to
14 give physicians, providing online medical
15 direction, training in that discipline as well
16 as making sure that they're well versed in our
17 local protocols. So I believe that there are
18 certain reasons, certain indications where a
19 mid-level provider -- and in those hospitals
20 where the mid-level provider is the only health
21 care provider in the hospital, there is a
22 physician on call but it's impractical to obtain
23 online medical direction from that on-call
24 physician. So I would definitely support, you

1 know, mid-levels under certain circumstances to
2 provide medical direction, online --
3 DR. MARSHALL: Yes.
4 DR. FAIRBANKS: I, respectfully,
5 couldn't disagree with the two of you more, and
6 I want to make the points. I think I've said in
7 the phone conference, which is to go on record.
8 One is that it is not standard, I believe, of
9 care to have mid-level providers providing the
10 only care in emergency departments. And the
11 fact that in this state there are some hospitals
12 that choose to provide substandard care in
13 emergency departments should not mean that we
14 should then say that we're going to have our
15 paramedics supervise at this level. To
16 summarize the arguments I'm hearing, I'm hearing
17 that the hand-off between what's happening at
18 the scene and the phone call to the receiving
19 provider, be it a mid-level or a physician, is
20 more important than the quality of the medical
21 control that is being received. Now, 20 years
22 ago when I practiced in the St. Lawrence County
23 region, Canton Potsdam Hospital did not have
24 online medical control, and EMS called

1 Watertown; Watertown gave orders, and then this
2 was then handed off to the receiving hospital
3 with no problems. Twenty years later we now
4 have technology that makes this even easier.
5 And I think that there are two main points here.
6 One is mid-level providers are not trained in
7 EMS in the same things that paramedics are
8 trained in. They are not trained to do things
9 like RSIs, which we have our paramedics do.
10 Some things we're hearing today, like
11 facilitated extrication using ketamine,
12 certainly it would be very unusual to have a
13 mid-level provider trained in conscious
14 sedation, which is what we're talking about with
15 ketamine. And it is not appropriate for them to
16 then be giving orders to paramedics to supervise
17 their care that they're not even trained to do
18 themselves, and that's what we're talking about
19 doing here. Particularly, when technologically
20 we have the availability to have fully trained
21 emergency physicians giving this online medical
22 control supervision. Secondly, and I think it's
23 just as important, is that we, as SEMAC, have a
24 responsibility to a second issue, and that is

1 furthering and improving visibility of paramedic
2 and EMS as a profession. And paramedics are --
3 essentially, they are physician extenders, just
4 as PAs and nurse practitioners are, and they
5 are, in my opinion, a parallel subspecialty of
6 prehospital care. This is a different specialty
7 than the paramedics and mid-levels -- I mean the
8 PAs and mid-levels have, and they should not be
9 supervising. Emergency physicians should. And
10 I think it's our responsibility to uphold the
11 standard. And it is not -- to have medical
12 control given to a different hospital by a
13 physician, then have that physician call the
14 receiving P.A. or nurse practitioner in another
15 hospital is not a big deficit or a problem. The
16 bigger issue is who is giving the online medical
17 control?
18 DR. MARSHALL: Dr. Cooley and then
19 Dr. Leinhart.
20 DR. COOLEY: Listening to the
21 discussion, it seems as if the biggest issue is,
22 and feel free to correct me if I'm wrong, but
23 not the lack of intelligence of mid-level
24 providers but the training involved. And it's

1 been pointed out that they're not, specifically,
2 trained in emergency medicine, and they're not,
3 specifically, trained in some of the procedures
4 the prehospital providers do. I, honestly,
5 would counter with that; in a lot of urban,
6 rural urgent care centers you've got medical
7 M.D., D.O. providers, that you could, probably,
8 make that same argument with. They're not all
9 -- I think, if you're EM boarded, I think you
10 sort of have a built-in -- you, supposedly, know
11 how to do this, but you've got other specialties
12 providing medical care and, theoretically,
13 giving medical direction to these providers that
14 may have even less involvement or interest than
15 mid-levels. The other issue about bringing --
16 letting exceptions to the rule come into play,
17 it was pointed out earlier, and we seem to have
18 this as a standard, we let CC techs do things
19 that are outside their scope of practice because
20 we give them additional training. It seems to
21 me the bigger question and the bigger issue here
22 is what is -- what type of training is needed?
23 What makes us comfortable? And I mean in the
24 Western region our REMAC -- excuse me, our

1 online medical course is six hours live, in
2 person, with scenarios with other people in
3 other rooms with radios, you know, giving them
4 case scenarios. Other regions, I'm sure, do it
5 differently and, potentially, just as well or
6 more, but this is, really, more about the
7 training and what we think anyone giving online
8 medical control should have, not -- I don't
9 think, so much, the specific level when you're
10 talking about mid-levels.
11 DR. MARSHALL: Dr. Leinhart.
12 DR. LEINHART: Let me just describe
13 some of the practices of PAs in the State of New
14 York. The standard that allows mid-levels to
15 staff largely rural emergency departments is a
16 standard. It's in the state law, so that cat is
17 out of the bag. It could be put back in, I
18 suppose, but the economics of health care in
19 this nation will, probably, make that
20 impossible. The availability of emergency
21 physicians to staff every hospital emergency
22 department, without incurring losses in
23 emergency departments, seems a steep challenge.
24 PAs do rapid sequence intubations and do

1 moderate sedation in these emergency
2 departments, so it's not outside their scope of
3 practice to know about those things. But on the
4 other hand, I don't think that, unless there's
5 some issues with communication systems, online
6 medical control can't be received by paramedics
7 from physicians. The PAs that I work with are
8 not seeking to provide online medical control.
9 And we have these discussions -- it's a lot like
10 drug discussions and protocols. We're having
11 these discussions because we're doing it in a
12 vacuum of data. We have no idea who calls
13 medical control for what, and there may be
14 systems that can inform us about that. But, you
15 know, getting a call for analgesia is a very
16 different call than tachycardia or other things
17 that the P.A. or other practitioners may require
18 a physician input to. So I would be -- I would
19 be comfortable with keeping a medical control
20 physician directed.
21 DR. MARSHALL: Dr. Henry.
22 DR. HENRY: I think that should be
23 the standard that doctors do the medical
24 control. And if they're not going to do it, we

1 should know why they're not doing it for various
2 reasons. And then you have to take it into
3 account when you make options under medical
4 direction, because we put a whole plethora of
5 options under medical control directed, and we
6 don't know who the medical control is. And I
7 would say that one of the critical steps there
8 is judgment. And as much as I respect PAs and
9 NPs, their curricula is very narrow compared to
10 a medical school curriculum. They just don't
11 have the knowledge base that a doctor does
12 because there is less years of training. You
13 know, a P.A. doesn't have to have a bachelor's
14 degree as a course of study. So you gain things
15 with experience, but the knowledge base is
16 something that you have to learn. And patients
17 are complex. And what I've heard from
18 paramedics in regions that could have doctors do
19 medical control that don't, they're often
20 working in hospitals, tertiary hospitals. They
21 know the complexity of certain patients they
22 care for, they're out in the field, and when
23 they call for medical control on complex cases,
24 they don't have an appreciation at the other end

1 for the type of patient they're caring for. So,
2 you know, I don't see, with technology, that it
3 can't be available. And I think, if it's not
4 available, we have to keep it really in mind,
5 when we look at protocols, that we're approving
6 here for options and say who actually is the
7 medical control physician?
8 DR. MARSHALL: Some of the other
9 topics that were discussed on the conference
10 call included the issue of where one particular
11 region or a hospital might find a physician
12 willing to provide online medical control for
13 that system. If there was no other provider --
14 no other physician in that area who was
15 knowledgeable or willing, then they would have
16 to go outside of their region to find somebody
17 who was capable and willing to do this and knew
18 the protocols in that specific region. So that
19 was one of the other issues that came up, I
20 guess, in support of having a physician
21 assistant. And I say physician assistant, but
22 I'm also including nurse practitioner because
23 they're also mid-level providers in New York
24 State. So, you know, there are plenty of docs,

1 even in my shop, who I would not want speaking
2 to a paramedic in the field because they don't
3 have a clue as to why the paramedic or EMT can
4 or cannot do or what their procedures are in the
5 field, so I think it's all -- a lot of it is
6 operator dependent. And when we try -- and when
7 we make an assumption that because we are
8 emergency medicine trained, boarded docs and our
9 two weeks of EMS rotation during our three years
10 of residency was sufficient to give us enough
11 knowledge than somebody who is coming straight
12 out, and we're putting them in a position where
13 they're going to provide online medical control,
14 they may not have the knowledge either. So each
15 region, I think, has to deal with those issues
16 about who is there, who is providing online
17 medical direction and online medical control as
18 opposed to medical direction, which I think it's
19 more overall the direction of the EMS system
20 than, actually, speaking with the field
21 provider. So I think there are a lot of issues.
22 I don't think -- you know, I certainly don't
23 have the answers. Dr. Broderick.
24 DR. BRODERICK: Yeah, I, certainly,

1 can't speak for other regions, but many of our
2 PAs are paramedics that actually continue to
3 work in the field and so have a very good
4 knowledge of -- and they started off there, and
5 they subsequently went to P.A. school. Some
6 naturally go to medical school. It just seems
7 like a bit of a strange message to send, I would
8 say, that -- and, first of all, technologically,
9 it exists. I agree that it could be all
10 physicians, even in our region. It just seems a
11 little strange that, again, under Public Health
12 Law in New York State, we're allowed to staff,
13 as Dr. Leinhart said, the cat's out of the bag
14 with this, with mid-level providers, lower
15 volume EDs, and, yet, we're going to say that
16 somehow the medical care provided inside the
17 ambulance is going to be better than the medical
18 care provided once the patient gets to the ED.
19 By virtue of a physician speaking to a paramedic
20 versus a mid-level provider, in which case then
21 we're stepping down, evidently, in the medical
22 care provided. So it could be done.
23 Technologically, there's no doubt about it. We
24 could structure that. I just don't see how or

1 why that is going to change, at least in our
2 region. There may be others, and I could see
3 working in higher volume EDs we always had docs
4 do this, and you'd think of no other one to do
5 it besides physicians, but how this would impact
6 medical care. I think we could, maybe, feel
7 better that all physicians are doing this, but I
8 can tell you it's not going to do a thing when
9 it comes to the medical care provided in the
10 field and then, subsequently, to the hand off in
11 the ED. And I might argue, it might send up the
12 wrong message to the physician extenders who,
13 actually, are so involved in the EMS and
14 interested that they're not worthy to talk to a
15 paramedic or critical care tech but they are --
16 they have to take care of them when they arrive
17 to the ED.
18 DR. HENRY: Just a couple points,
19 if I might. You know, just a point of
20 information. A lot of times when you ask people
21 how long was the patient down, you get like big
22 hits on five minutes and ten minutes and fifteen
23 minutes to five. So 15,000 ERs were using PAs;
24 that was one of those five, ten, fifteens. That

1 was an arbitrary point that was picked 15 years
2 ago when they did the appropriateness review
3 standards, because you had to pick something,
4 and that was based on economics. You know, it
5 was just saying it's just impossible, and maybe
6 on geography at some point in time, and maybe
7 that has to be reviewed again. At this point in
8 time, what are the economics that say that you
9 can't afford to have doctors in emergency
10 departments in hospitals in New York State,
11 where we export half the doctors we train to
12 other states? So that's probably worthy of
13 discussion. And then there is the creep that
14 happens from having mid-level provider staff
15 those ERs to now high volume ERs. Sometimes use
16 mid-level providers, but no doctor is seeing the
17 patients because of economics. So that's an
18 economic choice that people do that. That
19 doesn't necessarily mean it's better or worse or
20 more cost effective -- but I do think that this
21 variation -- we have to keep in mind, there's a
22 variation in practice in the State when we
23 discuss things like ketamine and other drugs
24 that in some teaching hospitals are only given

1 for procedural sedation by attendings, not even
2 by residents. There's rules and regs in some
3 hospitals in New York State that they wouldn't
4 give such drugs. We're talking about standing
5 orders. Medics that do this, or they're talking
6 to someone on medical control option? Who are
7 they talking to? So I think this is a very
8 important discussion, and we should, probably,
9 seek variation of practice and try to get
10 information on what type of calls are coming in
11 and what is the impact. You know, we get a lot
12 of push-back because drugs were denied. It's
13 like, oh, medication denied at medical control,
14 like the medics want to give it, but they don't
15 always appreciate the subtleties of afib and how
16 long you've had it and what the nuances are
17 there, and we don't necessarily teach that.
18 They don't need to know it, but those are things
19 you expect the physician to know. So I think
20 it's very rich. And I don't know how you're
21 going to continue this, Dr. Marshall.
22 DR. FAIRBANKS: Dr. Marshall --
23 DR. MARSHALL: There's always
24 follow up --

1 DR. FAIRBANKS: I just want to make
2 one follow-up comment. I just want to be clear
3 that I work with some mid-levels who I'd much
4 rather have answer the radio than some of the
5 physicians I work with, so it's not -- and I,
6 certainly, understand that there are some
7 hospitals that have done a good job utilizing
8 mid-levels. What I'm more concerned about is
9 the statewide message because other hospitals
10 may not do as good a job, and I just think we
11 need to maintain a standard because the
12 barrier's not that big. It's not a big expense.
13 Technologically, it's not difficult. So, unlike
14 staffing with mid-levels, which does have an
15 economic drive, medical control by mid-levels
16 doesn't have an economic drive because it
17 doesn't cost a lot of money to have a physician
18 at another site give the medical control, and I
19 would argue that there is not a lot of
20 difference in the hand-off; you know, what
21 happens, you get a call from a third-party
22 physician saying what you're going to get.
23 DR. MARSHALL: Just a quick straw
24 poll, because not everybody was on the

1 conference call, but including those in the
2 audience, please. If you think that medical
3 direction should only be provided by a
4 physician, raise your hand. And you can change
5 your mind later after the discussion, but --
6 SPEAKER: What was the question?
7 DR. MARSHALL: Do you feel medical
8 direction should be provided only by a
9 physician, medical direction as opposed to
10 online medical control? Okay, thanks.
11 DR. DAILEY: Specific offline --
12 DR. MARSHALL: Offline medical
13 direction, yeah. Okay, now, thank you. That's
14 protocol. Now, for online medical control, how
15 many think that a physician is the only person
16 who should be providing online medical control
17 to a provider in the field? I'm just going to
18 say M.D.
19 DR. FUNK: D.O.
20 DR. MARSHALL: Or D.O., sorry. A
21 physician. Okay, how about those who think that
22 it could be provided by a mid-level
23 practitioner, P.A. and nurse practitioner?
24 SPEAKER: Could?

1 DR. MARSHALL: Could or should,
2 could or should.
3 SPEAKER: Could or should is two
4 different --
5 DR. MARSHALL: Yeah, okay, so
6 it's --
7 DR. DAILEY: If I may, for a
8 second, Dr. Marshall, I think, you know, we've
9 gone around about this for a whole lot of
10 different reasons, but I think it's important
11 for to us remember, too, why this question was
12 asked. There were two different questions. The
13 first was whether or not at our smaller volume
14 rural facilities, where there is only a nurse
15 practitioner or P.A., which, notably, the Public
16 Health Law has very different oversight
17 regulations. And that was one side of that.
18 The other side of that was, actually, raised by
19 one of our field providers who attempted to get
20 medical direction at one of our more higher
21 volume sites and was denied the ability to talk
22 to a physician by a person of the exact same
23 level of training that the person calling in
24 was. We're not talking about a physician

1 assistant here. We're talking about a critical
2 care tech denying another critical care tech the
3 ability to talk to a physician. I think those
4 are very different, and I think it's important
5 for us to recognize that, from this body, I
6 agree with Dr. Fairbanks, in that what we should
7 do is set the bar high. I think we need to set
8 the bar high in terms of what the oversight of
9 these systems is going to be, the safety
10 mechanisms that have to be in place for both our
11 providers and for the people doing the medical
12 consultations. I think that, as a body, we
13 should recommend to every facility doing medical
14 consultation for our field providers that they
15 have every single one of these calls recorded,
16 if at all possible, so that they can be reviewed
17 for the protection of our patients, our
18 providers and our medical consultative people,
19 whoever they happen to be. But I don't think
20 that we can allow this to pass through this body
21 without saying that a physician should be
22 available for any medical consultative call in
23 New York State. It's required.
24 DR. MARSHALL: Okay, Dr. Young and

1 then Dr. --
2 DR. YOUNG: I can, maybe, shed some
3 light, being with the Department on the review
4 side and having a number of facilities in my 17
5 county region that do function with mid-level
6 staffing only. They're rural. We have some
7 CAHs, critical access hospitals, as well. There
8 are no requirements for the mid-level physician
9 extender to have any EMS background. As a
10 matter of fact, two of my four facilities, the
11 medical physician provides oversight. He's not
12 an emergency doc. He's a general practitioner
13 from the community. So my particular region is
14 the one that's had the two facilities recently,
15 and they were very egregious, so we're looking
16 into those now at the department level. That's
17 not to say that a P.A. could not -- or an RNP
18 could not give direction. We all know we have
19 good providers, and it does make a difference as
20 far as their background and training. And Mark
21 and I and others who were around back in the
22 early '90s, late '80s when at that time I was on
23 the other side of the force, as we call it, one
24 of you, and we -- New York ACEP, and we worked

1 with the Department to develop the staffing
2 standards for emergency departments, and we
3 remember the response we got, as I know see from
4 a regulatory side where we do have to put
5 regulations forward that go into Public Health
6 Law, there is a lot of input, and the hospital
7 association has a very large wait in the
8 decision-making process, and we were made aware
9 back then, if we were going to put the standards
10 in we all wanted, which was emergency medicine
11 trained docs, or boarded docs, at least, at that
12 time. I don't think we required -- well, we
13 wanted to, eventually, go that route, but we
14 would absolutely put places out of business, so
15 the compromise that you see is in the Public
16 Health Law. Nobody wanted that. We didn't want
17 hospital staff with mid-levels, but there was
18 just no alternatives, and there's still no
19 alternatives today, unfortunately. We're
20 dealing with facilities that now have even worse
21 financial conditions than they did back then.
22 So it's a tough situation, but the one positive
23 thing is we do have technology. And since most
24 medical direction, the vast majority of it in

1 the State, not in all areas, is done by cell
2 phone now. I mean you can easily dial in
3 someplace else and get that kind of direction.
4 And as far as the hand-off piece goes, there is
5 some of us, myself included, I'm still one,
6 medical director of air services, we're involved
7 in hand-offs all the time. We get in, we put
8 our two cents in, we suggest some things, and so
9 we're a third-party, and that does not -- I
10 don't think that impacts the care negatively. I
11 hope it impacts in a positive fashion, so it's a
12 complex issue, but I want you to be aware. And
13 I know there's excellent mid-levels, and I know
14 in some regions they have excellent training,
15 but there's an awful lot out there that don't
16 meet those kinds of standards. So as you go
17 forward, you've got to consider, I would say you
18 have to look at the weakest link as you're going
19 forward in something, so just bear that in mind
20 as well, too. I mean, ideally, whoever the
21 provider is, if they could get training, I am
22 sure that mid-level could handle most of the
23 protocols, but as we become technologically more
24 advanced in our protocols -- and ours tend to be

1 some of the best, I think, in the country, as
2 far as cutting edge -- the level of knowledge
3 behind that needs to go up as well. Sometimes
4 you can't always get that just by a short
5 course.
6 DR. MARSHALL: All right, it's
7 getting late, the hour is late. Do you have a
8 comment?
9 MR. ZEEK: Yeah.
10 DR. MARSHALL: Absolutely, please.
11 MR. ZEEK: I was just wondering, in
12 the hospital community, does anybody sense any
13 reluctance on the part of hospitals to take the
14 responsibility to provide medical direction for
15 patients that are not coming to that hospital?
16 I just wonder if that is an issue, because we're
17 -- I mean in my region we're getting medical
18 direction from two hospitals and servicing six
19 hospitals that are small hospitals, and we're
20 calling into the bigger hospitals for medical
21 direction, and we don't have any reluctance
22 issues. But I wonder in the hospital community,
23 at large, whether there is some discussion or
24 reluctance about that.

1 DR. COOLEY: I would just say, in
2 our region, there was some expressed, kind of
3 third-person expression of reluctance for that
4 in a particular area that this was happening,
5 but I didn't have direct conversations with the
6 hospital.
7 MR. WRONSKI: Can I suggest that
8 you don't ask. I'll tell you why. I won't go
9 off the record. I'll say it on the record. If
10 you ask, the only way to ask is to send a letter
11 to each CEO and say, do you know you provide
12 medical direction in your ED, and do you mind
13 that? All of a sudden, they will go to their
14 attorneys and say we provide medical direction
15 to these hospitals; what do you think about
16 that? And they'll answer something that a CEO
17 may not want to hear. And then you'll get your
18 answer. And all of a sudden what had been
19 happening for good will out of the ED is
20 stopped. And while I don't think that is true
21 in all regions, I do know this has happened in
22 the past; when an issue came up through the
23 wrong pipeline, other considerations were
24 considered and good will ended. So, you know,

1 unless -- and I haven't had any complaints to
2 that effect. If I start to hear them, I
3 certainly would share that with this group, but
4 I think it's an issue that unless you're going
5 to tell me there is an issue, I wouldn't make it
6 one.
7 MR. ZEEK: I just wonder if that
8 could be corrected at some point legislatively
9 with some kind of good samaritan legislation
10 that would absolve hospitals from, you know,
11 responsibility for providing direction for
12 patients that they're not going to see.
13 MR. WRONSKI: My best
14 recommendation is this body can only make a
15 recommendation to the Commissioner, but you
16 might -- if you believe it's an issue, you might
17 want to explore that and other avenues.
18 DR. MARSHALL: I think it might be
19 more of a liability issue than a responsibility
20 issue.
21 DR. HENRY: You know, these days
22 of, quote, tele-medicine, I think it's an issue
23 worth exploring. I mean lots of people are
24 trying to put up systems where they give

1 consultations from afar, save a lot of money not
2 having to transfer someone with packs, with
3 images being available now. I mean people make
4 these consultations. There's approval for
5 strokes for neurologists to do this. I think
6 this should be expanded, and maybe EMS should
7 look at this as an option for medical control.
8 I'll tell you, I think it makes a big difference
9 who you talk to, even in poison centers. You
10 get the information specialist, they give you
11 the most conservative line. You know, if you're
12 trying to do right and call and participate in
13 that for data gathering and whatnot, you'll get
14 advice about that. If you talk to a
15 toxicologist, you get another -- you often get a
16 different point of view, which doesn't lead to
17 admission; it leads to a lot of savings -- so I
18 think there is value in it, and we should
19 explore it with the Department.
20 DR. MARSHALL: Or, perhaps, you
21 could have the chair of the SEMAC, you know,
22 take all the phone calls. Well, it's going to
23 be a long discussion, I think, over the summer
24 because I don't think we're going to resolve it

1 here. Just, you know, keep in mind that -- you
2 know, review it, too. Look at it, and maybe we
3 can send out the surveys again -- the surveys,
4 the two surveys; one was pediatric and one was a
5 general survey about online medical control, as
6 well as 9501, which you should look at, because
7 we said that it had to be a doctor as opposed to
8 the language in the regulations. So we'll
9 continue with the group that met a couple of
10 weeks ago. We'll have an on-line -- well, an
11 offline, maybe e-mail discussions and other
12 things over the next couple of months and see if
13 we can't come together with some recommendations
14 for the group. And I'll entertain a motion to
15 adjourn. Thank you.
16 (Whereupon, the meeting adjourned at
17 11:40 a.m.)

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1 C E R T I F I C A T E
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3
4 I, Kyle Alexy, a Shorthand Reporter and
5 Notary Public in and for the State of New York, do
6 hereby certify that the foregoing record taken by
7 me is a true and accurate transcript of the same,
8 to the best of my ability and belief.
9
10
11 ___________________
12 Kyle Alexy
13
14 DATE: June 9, 2009
15

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