

-----  
NEW YORK STATE EMERGENCY MEDICAL SERVICES  
COUNCIL

(SEMSCO)

-----

Thursday, September 11, 2008  
9:00 a.m. - 12:00 p.m.  
Best Western Sovereign Hotel  
1228 Western Avenue  
Albany, New York

APPEARANCES:

Daniel Blum

Paul Bishop

Richard Brandt

Sharon Chiumento

Paul Cousins

Tim Czapranski

Robert Delagi

Donald DuVall

Donald Faeth

Vincent Faraone

Lester Freemantle

Debra Fults

Deborah Funk, M.D.

Marjorie Geiger

John Hassett

Bradley Kaufman, M.D.

Steven Kroll

Andrew LaMarca  
Alan Lewis, Sr.  
Lewis Marshall, M.D.  
Michael Mastrianni, Jr.  
Michael McEvoy  
Mark Murray  
James O'Connor  
Michael Quinn  
Walt Reisner  
Raymond Serowik  
Storm Treanor  
Michael Washington  
Edgar Wedge  
Edward Wronski  
Mark Zeek

1 (Roll call was taken.)

2 DR. FUNK: First, I'd like to thank you all for  
3 being here today, September 11, 2008. Seven years  
4 ago today, many of us were not in this room but in a  
5 different room here in Albany, and our lives and the  
6 lives of those around us were changed irrevocably.  
7 So I'd like for us now to take a moment of silence  
8 and, if you're so inclined, a prayer to recognize the  
9 changes that we've all seen happen over the past  
10 seven years and to recognize the efforts and the  
11 sacrifices of those in our community and in our  
12 country.

13 (Whereupon, a moment of silence was  
14 observed.)

15 DR. FUNK: Thank you. Understanding that this  
16 is a day that holds such importance to our country  
17 and specifically our EMS and emergency  
18 community, we have spoken with the Department  
19 and it will be of utmost priority in future years to do  
20 everything that we can to avoid having meetings  
21 scheduled on September 11th.

22 Moving ahead, we'd like to take a look at the  
23 5/29/08 minutes. Does anybody have any comments  
24 or would anybody like to approve those minutes?

1 MR. WEDGE: I'll move to approve.

2 DR. FUNK: Second?

3 MR. CZAPRANSKI: Second.

4 DR. FUNK: All those in favor of approving the  
5 minutes from May?

6 SPEAKERS: Ayes. Ayes. Ayes.

7 DR. FUNK: Any against? Abstaining? The  
8 minutes have been approved.

9 I didn't have any significant correspondence  
10 that needed to come to this body, so let me move  
11 ahead to EMS. Well, do either the first or second  
12 chairman have reports?

13 MR. FAETH: Not at this time.

14 MR. DELAGI: No report.

15 DR. FUNK: Okay. And I don't have anything  
16 that won't come up in other committees, so EMS  
17 staff report.

18 MR. WRONSKI: Thank you. I'll mirror the  
19 Chair's comments. This is an important day for all  
20 of us, an important day to remember. And I think  
21 this work, actually meeting sometimes on important  
22 days as a body, represents EMS, to put it on the  
23 State record how we feel and what we feel, and we  
24 still feel very strongly about the events of that day

1 this many years later. And I think we will, after I've  
2 retired and the next director moves on, and we  
3 remember what occurred on September 11th, the  
4 heroism of the EMS system during that date.

5 However, after discussing this with a number of  
6 people, I do want to reiterate this will be the last  
7 meeting we have on 9/11. It will not happen again.  
8 But I am still glad you're here and that we all have  
9 an opportunity to be together on a -- this day.

10 I do -- I want to start off the meeting with  
11 something I hadn't planned to put on my state  
12 report, but my plans literally -- I had a newspaper  
13 that I had thrown on my passenger seat in the car  
14 this morning, which I had read a couple of times.  
15 And it was in the Sunday Times Union, and it says --  
16 and this is dated September 7th, so it was only a  
17 couple days ago. It says, EMS In Critical Condition,  
18 and it's a front page article that the Times Unions --  
19 Union ran. They had called my office and asked  
20 some questions regarding EMS systems. I didn't  
21 know this was going to be on the front page. There  
22 were many other people in the system that they had  
23 spoken to, including regional people. There was  
24 Chris Knudsen here, from the Adirondack

1 Appalachian area, from the program director Phil  
2 Mulleedy, all very on the mark, all very honest,  
3 open, concerned responses about the system.  
4 Basically what it says is that we have a system in  
5 trouble in this particular area.

6 The reason I'm bringing it up is, as I've said  
7 before, and really, over a period of years, my office,  
8 in our day-to-day work with all of the different  
9 regions, including New York City, have noticed that  
10 it has been more difficult to operate the system as  
11 it exists, more difficult to find the volunteer sector --  
12 volunteers to give their time to EMS, and this is,  
13 again, as I've said before, and you know this, not  
14 limited to New York State. It's a national  
15 phenomena. It's more difficult in our day to find the  
16 people who can give additional time. It's not that  
17 they may not want to, but they just don't have that  
18 time to provide to EMS.

19 And so a variety of ways to resolve these  
20 problems in some cases is giving up volunteerism  
21 as we know it from twenty or thirty years ago, so  
22 that you have a hybrid system of paid staff during  
23 the day and volunteers at night, or a mixed crew, or  
24 in some cases, you have marriages between a

1 variety of services so that they can cover each  
2 other's territory when needed.

3 But more of this needs to be done, because  
4 these articles are coming up more and more. This  
5 isn't the only one. There was another one about a  
6 week ago in another part of the state, pretty much a  
7 mirror of this one. There was one in the New York  
8 Post down in the City talking about the difficulty  
9 FDNY is having in hiring career staff to take jobs  
10 with them, and I know from UNYAN that they've had  
11 difficulties. Their membership has indicated to  
12 them they've had difficulties finding people.

13 Yet our numbers of EMTs in the state -- and this  
14 is what we told the newspaper -- hasn't gone down.  
15 We still have more EMTs than we did ten years ago.  
16 We have more advanced providers -- significantly  
17 more advanced providers than we had ten years  
18 ago. But they're not necessarily in the system and  
19 they're not necessarily in the areas of the system  
20 that we need.

21 So I again bring this to your attention as an  
22 advisory group. I think that all the committees need  
23 to put this on their plate, not this particular article,  
24 but this problem, and that we need to do some --

1 have some discussions and potentially put together  
2 a small group to provide guidance to the systems.

3 What is it that we need? And I know people will  
4 say, Well, let's do more recruitment and retention.  
5 Let's -- let's come up with some tax incentives. All  
6 those things are positive. All those things help. My  
7 personal view is that in order to change the system,  
8 I believe the system literally needs to be  
9 reorganized and reconstructed, but -- and I think  
10 this body is one of the bodies that need to provide  
11 ideas to the Commissioner and ultimately, to the  
12 Legislature and Governor.

13 What does that mean? What -- what do we do  
14 to reconstruct our system so that two, three or  
15 maybe five years from now, you won't see these  
16 articles? But we're concerned at the state level and  
17 in the bureau. We believe this article is correct and  
18 there are significant problems that are growing and  
19 not getting less and that we need to be aware of  
20 that.

21 So the good news -- the good news is that there  
22 are people, core providers in EMS, who are always  
23 there and remain there. And the article kind of  
24 underlines that, with a given EMT who continues to

1 ride despite certain health problems. We have this  
2 all over the State of New York. We have core  
3 people who have ridden in EMS ten, twenty, thirty,  
4 forty years, probably more than that, and they make  
5 their ambulances run and the wheels turn. We'll  
6 always have those, but sooner or later -- and I think  
7 we're at the later part of this, the system does get  
8 into a crisis and those core people can't carry the  
9 load, because the load is increasing, as you all  
10 know.

11 Our latest data shows that we're upwards of  
12 three million plus total calls in the State of New  
13 York. A huge amount of patient transports and  
14 emergency calls. So we need a more robust  
15 system. We need a system that doesn't crush the  
16 core people who have given their lives to this  
17 system.

18 So one of my goals is that we start to have  
19 conversations specifically on that subject and  
20 maybe come up with some ideas over the next year  
21 to two years. This isn't an overnight thing, but I  
22 would ask the counsel to work with me on that.

23 Getting to more cheery news, the budget, the  
24 state budget -- maybe I'm -- my humor's not funny,

1 but the budget is not in good shape. We all know  
2 that. We know that Governor Paterson is making  
3 every effort to constrict the state budget. He  
4 particularly has immediate control as executive to  
5 limit the spending of state agencies and how they  
6 spend money. And we have had a series of  
7 memorandums, one that came in probably no more  
8 than two weeks ago or less, which was rather  
9 draconian. I've been in the state for 34 years, and I  
10 lived through the federal budget crisis in 1975, I  
11 think it was, in which a number of state employees  
12 who depended on federal dollars were laid off, and  
13 these were thousands of people. All right? But the  
14 State budget itself wasn't as impacted. It was the  
15 piece of the federal dollars. And there have been  
16 state budget crises, but nothing like this. Nothing.

17 And the memorandum is asking us to cut  
18 wherever we can, to support the statutory  
19 requirements, and unless it is an issue of patient  
20 safety and the health of the State of New York,  
21 we're to cut everything else and come up with ways  
22 not to spend money. And that's been my marching  
23 orders for a while now and it's going to continue to  
24 be.

1           And internally, what that means is we've had a  
2 variety of waivers for vacancies for employees  
3 denied. They had originally been approved. They're  
4 denied now. So this is not just EMS. This is across  
5 the state, all agencies, all bureaus. Everybody is in  
6 the same boat. So those things have been denied  
7 and the Department, the bureau, I believe, had four  
8 waivers that we were waiting to fill in the different  
9 offices and they're off the table now.

10           We have 23 EMS vehicles in the state. We are  
11 looking for ways to limit our mileage, to garage  
12 some of those, to use them less frequently and to  
13 bring down the cost of our fleet. And this is all  
14 fleets across the state. So we're doing those kinds  
15 of things.

16           There will be other things we do. One of them  
17 here is that you won't necessarily next year see  
18 cookies and such on the table for meetings. We'll  
19 be limiting how food is provided. We will provide  
20 food, but we may have to limit it to the actual  
21 members of the councils, and the guests may not be  
22 invited to the table, as has been our tradition. The  
23 people who come here who are not necessarily  
24 delegates to one of the councils but who participate

1 in council work and are on the subcommittees may  
2 not, next year, be invited to the dinner table, so to  
3 speak, although we appreciate your work and hope  
4 you can still come.

5 But we've been asked actually to cancel as  
6 many meetings as we can. All our travel has been  
7 stopped. The only travel we're able to still do is  
8 when I have a federal grant -- and this is kind of  
9 funny, because now it's the other side, but I have  
10 some federal dollars I'm allowed to use if there's a  
11 travel budget. There's some money in those federal  
12 dollars, but any state dollars in travel are going to  
13 be cut.

14 At the Vital Signs Conference, we normally  
15 bring all of our professional staff to the Vital Signs  
16 Conference to help us run the conference, 'cause  
17 there's plenty to do. We -- our staff worked typically  
18 from about six-thirty in the morning until about  
19 seven o'clock at night. And on the date of the  
20 awards ceremony, they work a little later, although  
21 some of them are working at a table next to the bar,  
22 so I won't count that. The -- but seriously, they put  
23 in a great deal of effort to make that conference  
24 run. I've had to cut eight people out of that core, so

1 you'll see less of us at the Vital Signs Conference  
2 because we're bringing down the travel costs. We  
3 will be able to run the conference, but we're  
4 bringing it down.

5 The other is that conferences across the state  
6 were cancelled. The first call I got -- and I had to  
7 have a call -- a private conversation with Donna  
8 Gerard that -- the first call I got a couple of weeks  
9 back was, You're going to have to cancel the Vital  
10 Signs Conference. And I gulped. And we had a long  
11 talk and then we went through where most of this  
12 money is paid for by people who paid their tickets --  
13 paid for their tickets. But there is cost to state staff  
14 going. The state staff are not picked up, in general,  
15 by the grant monies. They're paid for by state  
16 funds, so that's why I had to cut staff. We were  
17 allowed to continue the conference.

18 Other state conferences have been cancelled  
19 across the board in many of the agencies. This is  
20 going to continue for a while.

21 So these are the Governor's executive  
22 capabilities to look at his business, so to speak, and  
23 his employees and to save money. When you add it  
24 up across many thousands of state employees and

1 agencies, it adds up to hundreds of thousands of  
2 dollars and probably millions, when you're done.

3 I'm quite sure we're going to be lowering the  
4 lights at some point. The -- but you need to know  
5 this because -- not because the next thing I'm going  
6 to say is, Well, the EMS fund might shrink. It's not  
7 going to shrink. That's a pretty solid fund. I don't  
8 think anybody is going to suggest that that shrink,  
9 but I do not know about growth in the near future in  
10 any of these areas, and you needed to be aware of  
11 that.

12 Probably in the next two to three years, it will  
13 be very tight and we'll do a lot of our subcommittee  
14 talks by telephone. When necessary, we'll hold a  
15 meeting at a state office. People can come in. But  
16 we're going to keep those subcommittees tight,  
17 limited number. When we have the meetings, it will  
18 have to be a core group. I'm not going to be able to  
19 fund groups of ten or fifteen subcommittee  
20 members to meet. We're going to have to limit that.  
21 Subcommittees are going to have to re-examine  
22 that. Who do we really need to make this product  
23 move ahead?

24 So that's the state budget issue. I wanted to

1 make you aware of that.

2 Last time, I talked about diversity, and that's  
3 still on the table. We're still moving ahead to  
4 identify members to diversify our councils and  
5 committees. We've sent letters to the regional  
6 councils asking them to work locally and look at  
7 that issue locally. But again, for the record, let me  
8 make it clear, that what we're looking for is for  
9 councils, and this includes the REMACs, to look at  
10 how they get their membership, how they turn over  
11 their membership, how do you get new leadership in  
12 there.

13 Sometimes a council can get stuck and you see  
14 the same chair of a council or vice-chair of a  
15 council. Sometimes the whole executive board  
16 stays in place for ten or fifteen years and doesn't  
17 change. Well, you know what? That's -- that's not  
18 right. I know the answers. I know, in some cases,  
19 you'll say, Well, you know, we can't get people to  
20 give this kind of time and the people we've had here  
21 are doing a good job. At the same time, a  
22 percentage of any leadership group needs to bring  
23 in new blood periodically to move along, to change.  
24 And that's natural. That's what we do in our

1 political system. That's what we do here at the  
2 council, move leadership along, and that's what you  
3 need to do locally. But more importantly, you need  
4 to make sure that you're representative of your  
5 community, and we're asking councils to evaluate  
6 that, take a look at themselves and give us reports.  
7 Marjorie will give a short report about what we've  
8 heard from a number of the councils at this point.

9 I have, with the help of some associations,  
10 identified four new members who we will be  
11 working to place on some of our councils. Not all  
12 will be on the state council. We have SEMAC. I  
13 believe one of them will be placed on our State  
14 Trauma Advisory Committee. But we're going to  
15 continue this, to move along.

16 So, Marjorie, if you could give a brief report.

17 MS. GEIGER: Good morning. As our colleagues  
18 from the regional EMS council know, we sent out  
19 two letters to each chairperson, asking them for a  
20 plan of action concerning how they recruit members  
21 and how they plan to look at the compliment of their  
22 membership. Of the eighteen councils, we received  
23 nine respondents by the due date, so that was  
24 pleasing to us. We were disappointed that nine

1 chose not to respond or could not respond.

2 Of the nine respondents, all appeared to have  
3 some formal structure in place, either in their  
4 by-laws or operating procedures on how they  
5 outreach for new members -- a nominations  
6 committee, a membership committee, et cetera. So  
7 again, that's very positive.

8 Some councils actually undertook an analysis  
9 of the United States census population for their  
10 respective region and got an understanding of the  
11 types of individuals that live in their community,  
12 compared it to the compliment of their membership,  
13 and one or two actually took it a step further and  
14 compared it to a compliment of EMS providers in  
15 their community. So they did some really intensive  
16 pattern analysis, which provided a snapshot of the  
17 patients they serve, the providers that they have,  
18 and who represents those providers and patients on  
19 their councils and on their REMACs.

20 And then, of course, you know we recognize  
21 that everything is local. Each -- of the nine  
22 respondents, each council took a different approach  
23 how to look at this larger issue of membership  
24 recruitment. One council told us quite firmly that

1 they were quite comfortable with their existing  
2 structure and they don't recommend any change in  
3 how they recruit members or how they compliment  
4 their membership.

5 Others did some very serious soul searching  
6 and said to themselves, We need to change how we  
7 do business. We looked at the longevity of our  
8 members and we need to find ways to reach out,  
9 whether it's to younger members of their community  
10 or other gaps that they've noticed in their analysis.

11 Some folks looked at the process by which they  
12 recruit new members and they realized they need to  
13 strengthen that process and they'll be working on  
14 that over the next six, twelve and eight-month  
15 period.

16 It was an interesting reflection and one that we  
17 need to give pause to. Some -- two councils, in  
18 particular, said that when they looked at the  
19 compliment of their EMS providers in their  
20 community, they noticed that the provider  
21 community was also under-representative for  
22 certain population groups, so that -- that restricts  
23 them in many ways on new faces they could pull in  
24 to be their council membership.

1           So we suggest this may be an ideal time to  
2 have a partnership with your EMS core sponsors or  
3 your employers in the region and to work on that.

4           And we did receive an e-mail from two  
5 commercial carriers, who do have some special  
6 work with inner-city youth projects, in which they're  
7 hoping to strengthen those partnerships between  
8 public schools and bringing young people who've  
9 been untapped for the field of EMS into their -- not  
10 only ambulance service, but also the core  
11 sponsorship that they have.

12           And others realize that they need to develop  
13 partners with individuals and organizations outside  
14 their traditional realm, and this will include the  
15 business community, again, the schools, and some  
16 other community organizations that they have  
17 historically not had meetings or attended their  
18 functions.

19           So again, it was a very positive response that  
20 we received from the nine councils. We're pleased  
21 to know that they're taking this initiative very  
22 seriously. Thank you.

23           MR. WRONSKI: Some more specific items. On  
24 August 1, 2008, we sent a letter to all services

1 regarding changes in Ryan White, and I discussed  
2 this in previous meetings but the letter had not been  
3 composed and finalized. It's now finalized. This  
4 letter also went, in modified form, out from the  
5 Office of Fire Protection and Control and the DCJS,  
6 the Department of Criminal Justice Services, to  
7 both fire and police agencies, because the dropping  
8 -- and I'll remind those of you who don't remember  
9 this. The federal law that created Ryan White  
10 dropped the emergency provider section so that  
11 first responders are no longer covered under the  
12 Ryan White provisions for getting information about  
13 infectious diseases, including HIV. That is being  
14 looked at at the national level. It hasn't changed  
15 yet, but it's still being looked at. What we did is we  
16 found out from Public Health -- there's a section in  
17 Public Health Law that exists that allows for the  
18 release of HIV information if there is an exposure.  
19 And so this letter goes through that process and  
20 how it's different, but how you can, in fact, get  
21 information regarding your potential exposure to  
22 HIV. It is limited to HIV, different from Ryan White,  
23 but how you can get that information.

24 COURT REPORTER: Can you speak into the

1 microphone? I'm having a hard time hearing you.

2 MR. WRONSKI: I'm sorry. If there's a specific --  
3 is that better? If there's a specific exposure that  
4 has been documented and confirmed and agreed to  
5 by the hospital representative and your physician  
6 representative. So the letter goes through those  
7 steps and describes that. If there's questions on  
8 this, you can certainly ask me today, but you're  
9 welcome to call our staff to -- to inquire on any  
10 points you're not -- may not be clear of in this letter.

11 The -- another law change. It had been in the  
12 works for a while, but on July 7, 2008, the Governor  
13 signed Chapter 197 of the Laws of 2008, which  
14 allows for use of an alternative form to the New  
15 York State non-hospital DNR order. So we've had  
16 the single page, non-hospital DNR order for quite a  
17 long time -- I think it goes back to '92 -- which says  
18 if the patient doesn't want to have CPR done when  
19 they're in cardiopulmonary arrest, you do not have  
20 to do it if they sign this DNR form or if they have a  
21 DNR bracelet. The new law has allowed the  
22 Department to approve an alternative form. And  
23 although the law doesn't specifically mention that  
24 form, the form is MOLST, Medical Orders for Life

1 Sustaining Treatment. This body allowed for a pilot  
2 in the Monroe-Livingston area in which they piloted  
3 for pre-hospital, the MOLST form. MOLST has been  
4 used in different parts of the state because it didn't  
5 require a change in law for hospitals to use it and  
6 nursing homes, et cetera. But for EMS to honor it,  
7 we needed, actually, a change in legislation. So we  
8 got that, and now this form is in place. The -- one of  
9 the key differences is that form has a very specific  
10 section that not only discusses, Do I want DNR or  
11 not, Do I want cardiopulmonary resuscitation, but in  
12 my last stages of life, when you come upon the  
13 scene and this person is not in full cardiopulmonary  
14 arrest, but is in -- and I'll read the language. I think I  
15 have it here -- When the patient is deemed to have  
16 progressive or impending pulmonary failure without  
17 acute cardiopulmonary arrest, and you would have  
18 normally intubated this patient, if the patient signs  
19 the MOLST form and indicates in the section that, I  
20 do not want to be intubated in this case, you don't  
21 intubate. And that form specifically addresses that.  
22 There's no change to the state form, but there is a  
23 change now across the state, if the patient has a  
24 MOLST form in place, that you can withhold that

1 intubation in this type of instance.

2 The organization, Blue Cross Excellus, led by  
3 Dr. Bomba, has updated their training program and  
4 it's specific to EMS training that they've piloted in  
5 the Monroe-Livingston area -- or rather -- I'm sorry.  
6 It's the Monroe-Onondaga County. Right? Correct.  
7 I always forget that. It's Monroe-Onondaga County  
8 area, and they've updated that EMS training, and it's  
9 on their website. They will also be at our Vital  
10 Signs conference, and there will be a short  
11 presentation about MOLST at the education section  
12 -- session, and at our EMS table, we will have  
13 materials that will available but which you can also  
14 get, you know, online and seek their training online.  
15 I would remind everyone that this is not a  
16 Department of Health form. It's not a Department of  
17 Health process, but we have approved it, and it  
18 does come through a private organization. So it's  
19 an alternative. You may see it in your area. It may  
20 ultimately be the primary form in the State of New  
21 York, but that's going to be driven by patients and  
22 by the healthcare industry.

23 So I did send a memorandum out July 18th, to  
24 all the regions, and I sent it out, also, to the

1 counties to advise them of this information. And I  
2 suggest in your region, that you go on the website  
3 and look at the training program and see if you have  
4 any questions.

5 The -- we are moving ahead with regulations,  
6 still working with Dr. Linden and her bureau to put  
7 in place regulations that will allow EMS to transport  
8 a patient with blood running. That's not finalized  
9 yet, but a lot of progress has been made on that. So  
10 I'm hopeful that before the year's out, we'll have a  
11 final product to move forward into the regulatory  
12 process.

13 There were two significant court cases that I  
14 wanted to make -- put on the record, and one is the  
15 City of Utica ambulance service. This was a  
16 municipal CON that was filed by the City of Utica. It  
17 was approved and the City of Utica operated an  
18 ambulance service for two years. As you know, the  
19 municipal CON process requires that two years  
20 later, the municipality come back to the regional  
21 council and file a Certificate of Need. The City of  
22 Utica filed papers that they did not have to do that.  
23 They did not believe that this was required in the  
24 law. The Department of Health as well as the

1 regional council, but clearly the Department of  
2 Health, disagreed with that, and we went to court  
3 on this and the Attorney General was defending  
4 both the Department and the regional council. And  
5 the final decision came in just recently, and the  
6 Department's position with the regional council has  
7 been upheld. The -- any municipal CON does -- at  
8 the end of the two-year period, that municipality  
9 does have to come back to the regional council and  
10 file a Certificate of Need. The City of Utica has  
11 decided not to further appeal this case and will be  
12 filing a Certificate of Need with the council. And I  
13 appreciate, for the record, the council's patience in  
14 this and their work to make this happen correctly  
15 and appropriately.

16 The Supreme Court in Onondaga County has  
17 granted an Article 78 position and annulled the  
18 Department's expanded Certificate of Operations for  
19 North Area Volunteer Ambulance Corps. This was a  
20 case which specifically had to do with  
21 grandfathering. As you know, the statute that  
22 originally grandfathered existing ambulance  
23 services into the certification process back in 1974  
24 and 5 only had a six-month life. All ambulance

1 services had to apply back in 1975 to establish  
2 themselves as an existing ambulance service, and  
3 on their applications, they put their geography.  
4 Well, what occurred is that many, many ambulance  
5 services -- there were a handful that did not meet  
6 the timeframe, and the Department allowed them to  
7 put their applications in late, but many ambulance  
8 services didn't put the geography in correctly. And  
9 potentially, in some cases, the Department may  
10 have issued a certificate incorrectly.

11 So there were a lot of reviews over the years of  
12 existing ambulance territory by the Department and  
13 corrections made to certificates when the service  
14 was able to provide very clear and convincing  
15 evidence that they've always operated in that area.  
16 Nobody generally disagreed in the community, but  
17 rather than go through an amended CON process,  
18 the Department considered that we had the  
19 authority to correct a certificate.

20 This was challenged recently in Supreme Court,  
21 and the court said -- and there were a variety of  
22 reasons they said this, but certainly one of the  
23 highlighted ones is that we're talking it's thirty  
24 years later. So the court agrees that at this point,

1 everyone should have known whether or not the  
2 certificate was correct or incorrect, and it's not  
3 appropriate thirty years later to be looking at  
4 issues. If there are issues, they need to be brought  
5 to the regional council. So we will be sending a  
6 letter out to councils on this. Even though we have  
7 stopped already the grandfathering process a  
8 couple of months back, the letter will indicate that  
9 this is now formalized. There will be no more  
10 revisions of ambulance operating certificates, their  
11 geography, based on the old grandfathering  
12 statutes, and that comes partially out of the  
13 Onondaga County decision, but also the  
14 Department. I had discussed, as I told you earlier,  
15 with the executive staff that we were moving in this  
16 process. The court agrees with that.

17 The last thing I wanted to say is once again, the  
18 EMS system has been stressed in the country with  
19 the hurricanes that have hit the southern part of the  
20 state. There's one heading for Texas right now that  
21 doesn't look very good. But New York State  
22 emergency services did, you know, provide some of  
23 their ambulances in federal contract. All right? For  
24 the record, the Department did not deploy any

1 ambulances. The ambulances from New York State  
2 that were sent were sent as part of a federal  
3 contract, but I do applaud the work that those  
4 services did in those devastated areas, as well as  
5 all the other EMS services. So, thank you.

6 And unless there is any other questions, my  
7 report's done.

8 MR. LEWIS: Question on training for use of  
9 blood products. Can you clarify that -- did you say  
10 that legislation will be finalized by the end of the  
11 year? Is that what your comment was, Mr. Wronski?

12 MR. WRONSKI: No. Not legislation, but  
13 regulation.

14 MR. LEWIS: Regulation.

15 MR. WRONSKI: It won't be finalized.

16 MR. LEWIS: Okay.

17 MR. WRONSKI: What will happen is -- my hope --  
18 we've come to some agreement on language both  
19 for training and the regulation.

20 MR. LEWIS: Okay.

21 MR. WRONSKI: And if things keep moving as  
22 they do, then I would expect that regulations, all  
23 right, that we -- that we agree would be the proper  
24 language, would be introduced into the regulatory

1 process before the year is out, and then, whatever  
2 time it takes for that to clear the process --  
3 hopefully fairly quickly -- you'll see regulations that  
4 will support EMS transporting patients with blood  
5 running sometime next year. Hopefully, earlier in  
6 the year rather than later. But the process of  
7 developing those regs, getting them introduced to  
8 the process as final language, will be finished, in my  
9 view, before this year is out.

10 MR. LEWIS: So typically, they need to be  
11 published for comment for a period of time. What's  
12 that time frame? Is it ninety days or is it a longer  
13 period of time?

14 MR. WRONSKI: It's less than that. I believe it's  
15 forty-five --

16 MR. LEWIS: Forty-five?

17 MR. WRONSKI: -- forty-five day comment  
18 period, and unless there are significant  
19 overwhelming comments that require the  
20 Department to reconsider the regulation, then it  
21 goes into the next phase of approval. So if we're  
22 able to publish them and have a comment period  
23 this year, then you can see them early next year as  
24 a reality. But if they're not published until next

1 year, then sometime in the spring, you'll see them.

2 MR. LEWIS: Our hospitals continue to ask us if  
3 we can manage blood products, and it is stressing  
4 them to provide nurses to go.

5 MR. WRONSKI: They talk to me, too.

6 MR. LEWIS: Thank you.

7 DR. FUNK: Any other questions for Mr.  
8 Wronski? Thank you.

9 I'm reminded that if you intend for us to be  
10 compliant with the mandate to webcast and allow  
11 our colleagues at home to view us, you must stay  
12 off the internet. Yesterday we got bumped off the  
13 internet, 'cause I guess the lines were too small to  
14 handle it all. Please stay off the internet so that we  
15 can continue to webcast today. Thank you.

16 Dr. Henry was unable to be here today. I think  
17 Dr. Lewis has -- I'm sorry, Dr. Marshall has some  
18 report. He's right next to me. Thank you.

19 DR. MARSHALL: Well, the only report I have is  
20 for medical standards, so if you want to start that  
21 now, we can start that now, or wait.

22 DR. FUNK: I'm excited to start the medical  
23 standards report.

24 DR. MARSHALL: I was afraid you were going to

1 say that.

2 Good morning. What I'd like to do first, with  
3 your permission, is go through the protocols that  
4 were approved at medical standards and at REMAC.  
5 There was some protocols that were discussed and  
6 approved at the May meeting that were not  
7 approved at SEMAC because of a quorum issue.  
8 And they're not in any particular order, and they do  
9 require a roll call vote, I believe. So we have four, I  
10 believe, that will require a roll call vote. So --

11 The first protocol was actually a withdrawn  
12 protocol, and that was from Central New York.  
13 Central New York had presented a protocol that  
14 included the use of propofol in prehospital  
15 intubation for RSI as a single agent. They withdrew  
16 that protocol yesterday.

17 Nassau County presented a protocol on  
18 suspected cyanide toxicity. This protocol provides  
19 for the use of BLS activities as well as, under  
20 medical direction, the use of Hydroxocobalamin,  
21 which is a single agent for cyanide toxicity that is  
22 now available, as well as sodium thiosulfate. Both  
23 of these agents are available under medical  
24 direction only. Hydroxocobalamin is not going to be

1 carried on the ambulance but will be available for  
2 mass casualty incidents and disasters, and that was  
3 discussed and approved by medical standards and  
4 SEMAC and comes forward as a second in motion.

5 DR. FUNK: Is there any discussion on the  
6 Nassau cyanide toxicity protocol? Hearing none,  
7 can we have a roll call vote, please?

8 (Roll call vote taken.)

9 DR. FUNK: Sounds like it passes. Fabulous.  
10 Thanks. Next?

11 DR. MARSHALL: The next protocol comes from  
12 New York City, and they presented protocol  
13 changes to both the general operating procedures  
14 and to clinical protocols.

15 Under general operating procedures,  
16 transportation protocols were amended to allow for  
17 physician-directed transportation of patients with  
18 acute ST elevation MI, identified by the prehospital  
19 provider, to a facility that has 24/7 capability of  
20 providing interventional cardiology services.

21 Airway management. Some definitions of shock  
22 and decompensated shock. Prehospital sedation  
23 was moved to the general operating procedures and  
24 taken out of the various protocols where that

1 procedure is done. So I just have it listed once.

2 Endotracheal drug administration was removed  
3 from all protocols. Intranasal drug administration  
4 for certain medications was included.

5 Pharmacology table and pediatric dosage and fluid  
6 administration and how -- you know -- how to do it,  
7 what the dose is and the appropriate fluid  
8 administration dose.

9 Under their clinical protocols included  
10 respiratory arrests, obstructed airways, D-FIB,  
11 D-TAC, pulses say V-FIB V-TAC, suspected MI, drug  
12 therapy of MI, acute pulmonary edema protocol,  
13 asthma, COPD, altered mental status, seizure, head  
14 injuries, burns, pain management for isolated  
15 extremity injury, emotionally disturbed, pediatric  
16 asthma wheezing -- pediatric asthma wheezing was  
17 a change of title, okay? So it went from asthma to  
18 wheezing -- and pediatric seizures.

19 Included in those -- a lot of them were just  
20 wording changes to make the protocols more clear.  
21 There were very few substantive changes.  
22 Substantive changes included eliminating  
23 endotracheal administration of medications, and I  
24 believe that was it.

1           The motion that comes forward is that the New  
2           York City protocols were approved, including GOP  
3           and BLS and ALS protocols, with the following  
4           changes: Removing changes to 502 -- protocol 502,  
5           which is the obstructed airway protocol, and New  
6           York City had put in their procedure that -- we  
7           weren't sure of, so they withdrew that procedure  
8           out of that protocol and removed those changes so  
9           the protocol will remain as it was originally.

10          Recommended checking blood glucose for patients  
11          under the seizure and altered mental status  
12          protocols and changing the term Breslow in the  
13          pediatric protocols where it refers to Breslow tape  
14          to a term length-based measuring device, and there  
15          was some discussion on that because of trying to  
16          get away from using proprietary names in state and  
17          regional protocols. So we are changing -- going  
18          through and changing that.

19          The same thing was done in the weapons of  
20          mass destruction protocol, where we changed the  
21          name. Mark I kit or Duodote has been eliminated  
22          and we're just using medication dosages instead.

23          So that comes forward as a seconded motion.  
24          If you have any questions about any specific

1 protocol, I can answer it.

2 DR. FUNK: Questions? Roll call, please.

3 (Roll call vote taken.)

4 DR. FUNK: Thank you.

5 DR. MARSHALL: Moving right along, the next  
6 protocol that comes forward is from the western  
7 region. This was approved in May -- western region  
8 protocols were approved in May, with the following  
9 changes:

10 Under their protocol for high degree AV block,  
11 changing and using transcutaneous pacing before  
12 atropine. In addition to that, in their respiratory  
13 protocols, they allow for EMT-C to use CPAP, and  
14 the curriculum that will be used to train the CC and  
15 the CPAP will be the paramedic curriculum that is  
16 currently in place.

17 And there was a lot of discussion about  
18 protocols where a provider level is going to be doing  
19 a skill, and we want -- if there's no curriculum -- we  
20 want to use curriculum that exists. So in this case,  
21 for all regions who want CC to do CPAP, they should  
22 use the paramedic CPAP curriculum that currently  
23 exists. That was one of the things that came out of  
24 that discussion.

1           For the western region, also, they had put in  
2 place a protocol for pre-hospital post-arrest active  
3 cooling for patients with ROSC, return of  
4 spontaneous circulation. And there's a big push in  
5 hospital and out of hospital around the country  
6 because of the increased intact survival and how to  
7 discharge from hospital, inpatients who have  
8 certain types of arrests.

9           A lot of hospitals are looking at this issue and a  
10 lot of EMS systems are looking at this issue, but  
11 medical standards and SEMAC did not feel at this  
12 time that we are ready to approve that for New York  
13 State. But they're still looking into it. New York  
14 City is also looking into it and getting hospitals  
15 involved in -- in having this service available to  
16 patients from the field.

17           So with those changes, western regional  
18 protocols were approved, and that comes forward  
19 as a seconded motion.

20           DR. FUNK: Questions? Roll call, please.

21           (Roll call vote taken.)

22           DR. MARSHALL: Continuing right along. I have  
23 a few here.

24           DR. FUNK: Really.

1 DR. MARSHALL: The next protocol that comes  
2 forward as a seconded motion is from Hudson  
3 Valley, and the Hudson Valley protocols were  
4 approved. Again, Hudson Valley has the EMT-Cs  
5 providing CPAP for certain of their protocols, and  
6 again, it was approved with the understanding that  
7 they will use the current paramedic curriculum in  
8 CPAP. That comes forward as a seconded motion.

9 DR. FUNK: That sounds easy. Any questions  
10 there? Another roll call vote, please.

11 (Roll call vote taken.)

12 DR. MARSHALL: Thank you.

13 DR. FUNK: More?

14 DR. MARSHALL: More. The next group of items  
15 are motions that were made at medical standards  
16 and approved at SEMAC, both at the May meeting  
17 and at yesterday's meeting, and they do not involve  
18 regional protocols. Well, not directly. Indirectly.  
19 Well, maybe directly. And I'll leave it up to you as to  
20 whether or not you want a roll call vote on any of  
21 these.

22 The first motion that comes forward is one to  
23 interpret the word "intubation" to include all  
24 advanced airway devices. Back in May, we had a

1 discussion about patients being intubated and what  
2 was an advanced airway device. Was it just an ET  
3 tube or was it the other devices that are currently  
4 available on the market?

5 So originally, the motion was to have the term  
6 "intubated" or "intubation" include all the advanced  
7 airway devices that are currently existing. That  
8 motion was rescinded. Okay? So nothing to do  
9 about that, but that -- I think that's important  
10 information as we move forward on some of the  
11 other motions.

12 The next motion was discussed yesterday, and  
13 the motion is that the use of glucometry devices is,  
14 or are, the standard of care to determine blood  
15 glucose levels for all BLS and ALS blood glucose  
16 monitoring. And there was some discussion about  
17 this motion requiring BLS agencies to do blood  
18 glucose monitoring, and that's not what it does. But  
19 if you do have a BLS blood glucose monitoring, as  
20 they do in Albany, then you need to use a  
21 glucometry device. The reason that was discussed  
22 -- or one of the reasons that was discussed  
23 yesterday was that some regions might have been  
24 using the old dextrose sticks, which require a drop

1 of blood to be put on the end of the stick and then  
2 you wipe it off and you wait for the color to change.  
3 And we felt that -- or some people felt that this was  
4 -- puts the provider at risk for blood exposure, and  
5 with the new glucometry devices and their accuracy  
6 and their ease of use, it makes sense that we  
7 should use this device if we're measuring blood  
8 glucose in the field. So that comes forward as a  
9 seconded motion.

10 MR. WRONSKI: I don't believe this requires a  
11 roll call vote. If anybody wants to comment on it -- I  
12 don't see it as a -- as a specific roll call vote, but I'd  
13 just clarify that BLS ambulances who would be  
14 affected by this are only those ambulances who  
15 have limited -- limited lab approval to do this, and it  
16 would be expected they would use a glucometer --  
17 glucometer.

18 DR. MARSHALL: The other thing that, as Ed just  
19 mentioned, that was discussed yesterday was the  
20 CLIA waiver process that agencies would still have  
21 to go through if they wanted to do this.

22 DR. FUNK: So as I understand it, then, medical  
23 standards and SEMAC voted that if you are going to  
24 be checking blood glucose, you should be using a

1 glucometer. That is the standard of care.

2 DR. MARSHALL: Correct.

3 DR. FUNK: And that's what you're bringing to  
4 us today.

5 DR. MARSHALL: Correct.

6 DR. FUNK: Any comments on that? Yes.

7 MR. HASSETT: Just a brief one, and that is that  
8 perhaps this body can make a recommendation that  
9 a letter be sent to the lab division of the Department  
10 of Health requesting that they consider removing  
11 ambulances as a requirement to have a limited lab  
12 license, in view of the fact we're buying off the  
13 shelf, commercially available to the average citizen,  
14 testing devices and they're not the type that is  
15 normally used in a laboratory.

16 MR. WRONSKI: I'd just like to get the feeling of  
17 the group. Is that something that the group as a  
18 whole supports? I'm not necessarily opposed to  
19 this. What I can do is speak to the lab people about,  
20 you know, waiver possibilities. If I'm not mistaken,  
21 we did that originally and were not successful, but --  
22 you know -- John's sentiments and sentiment of the  
23 council group?

24 DR. FUNK: Any comments?

1           MR. MURRAY: I would suspect that that's not  
2 going to fly well with them, because I think their  
3 intent is that if you're doing testing outside of the  
4 home, if you're performing some sort of a laboratory  
5 analysis, which is essentially what a glucometer is,  
6 that there has to be some oversight of that.

7           I do think that the division of labs has relaxed  
8 somewhat the requirements for EMS services to  
9 obtain the waivers and the permit to do that, but  
10 their relaxing of it has been more ignoring some of  
11 the requirements than actually changing the  
12 requirements.

13           And I might suggest what we do is approach  
14 them with some more realistic requirements for  
15 EMS rather than -- you no longer have to submit a  
16 map of your ambulance to show where you're  
17 storing the meter, which used to be in the  
18 requirements. You can just submit a form that says  
19 that you're running an ambulance or a fire truck.

20           But I still think that some of the requirements  
21 that they have are somewhat ludicrous once you try  
22 to apply them to EMS service, and it might be wise  
23 to talk to them about making something more  
24 realistic. I don't know.

1 DR. FUNK: Other thoughts or comments?

2 Okay. The motion then is to approve the medical  
3 standards and SEMAC decision that use of  
4 glucometers when measuring blood glucose  
5 pre-hospital is the standard of care. We can add  
6 onto that the concern about the current CLIA waiver  
7 process and the suggestion that discussion happen  
8 regarding the current process between the  
9 department and the lab folks.

10 MR. DELAGI: Second. I would just add, in case  
11 everybody is not aware, that the CLIA folks have  
12 stood fast in their position that even for agencies  
13 using dextrose sticks, a permit waiver was still  
14 required. So this movement is really more of a  
15 safety issue to reduce needle stick and blood  
16 exposure than it is to do anything else. And folks  
17 should not look at this as now having to do a CLIA  
18 waiver because they're giving dextrose in favor of  
19 monitoring. That was required.

20 DR. FUNK: Thank you. Any other comments?

21 All those in favor?

22 SPEAKERS: Ayes. Ayes. Ayes.

23 DR. FUNK: Against? Abstain? Passes? Thank  
24 you. Is that it?

1 DR. MARSHALL: No. Would you like to take a  
2 break?

3 DR. FUNK: No.

4 DR. MARSHALL: No? Not yet? Okay. I have  
5 more. Always more.

6 There was some discussion yesterday about  
7 the availability of defibrillation in the State of New  
8 York and the benefit -- known benefit that early  
9 defibrillation has been shown to have on patient  
10 outcome. There was also some realization that  
11 perhaps there might be a small number of  
12 ambulances in New York State that are transporting  
13 or treating patients at a scene that do not have that  
14 capability. So after some discussions at both  
15 medical standards and SEMAC, the following motion  
16 was approved and comes forward. And the motion  
17 reads: All ambulances treating or transporting  
18 patients must have defibrillation capacity for all  
19 ages.

20 There was also discussion about the interaction  
21 between medical issues and operational issues and  
22 that this was not necessarily requiring every agency  
23 to go out and buy an AED. I mean, if you have an  
24 agency with ten ambulances and they have eight

1 defibrillators, whether they're manual or AEDs, that  
2 a defibrillation device needs to be on the ambulance  
3 when they're treating or transporting a patient.

4 That was -- that was the issue. But there was some  
5 discussion about the operationalization (sic) of this  
6 statewide, especially in some smaller services and  
7 the costs involved, but the motion passed  
8 unanimously.

9 DR. FUNK: As I recall from the discussion  
10 there, the thought was that this would affect a very  
11 small number. I certainly -- I see some heads  
12 shaking back and forth, but that we were not  
13 expecting that there were a lot of ambulances in  
14 New York State that did not have defibrillators  
15 currently. But it came to our attention that there  
16 were a few, and it was of great concern to us that  
17 an ambulance could show up somewhere and not  
18 have the capacity or the capability to defibrillate  
19 someone when elementary schools are mandated to  
20 have the same. So that's what the -- part of the  
21 discussion. Yes?

22 MR. MASTRIANNI: Doctor, just a point of  
23 clarification. If one of my ambulance services has  
24 five ambulances but only uses three, the other two

1 are used as backups if one goes down mechanical,  
2 as they often do with jump kits, oxygen, whatever,  
3 is this stating that every certified vehicle has to  
4 have an AED or only those vehicles that would be in  
5 the rotation to respond to treat patients?

6 DR. MARSHALL: That -- the discussion was that  
7 only those vehicles that are actually transporting or  
8 treating patients. So if you have ambulances that  
9 are out of service or, you know, sitting in the garage  
10 because they have a flat tire, no, you don't have to  
11 have one on the vehicle. But if you're going to  
12 transport a patient or if you're treating a patient at  
13 the scene of a mass gathering, let's say, then you  
14 need to have one. That was the sense of the  
15 motion.

16 MR. BLUM: Hi. Dan Blum from the Westchester  
17 region. Just another point of clarification. I believe  
18 you used the term "capable of treating all ages,"  
19 and I'm not sure if AEDs are capable of treating all  
20 ages. For instance, newborn. So we might want to  
21 clarify that.

22 DR. MARSHALL: Yes. The discussion -- there  
23 was some discussion on that, with  
24 recommendations that -- and it's not -- the motion

1 was not to recommend that everybody run out and  
2 buy pediatric-capable AEDs or pads or replace your  
3 existing ones. We've had that discussion at the  
4 table before. But as you replace units or upgrade  
5 units that you currently have, we're -- I think the  
6 state is requesting or demanding that you upgrade  
7 to pediatric-capable. So we're not doing anything in  
8 addition to that. It's just whatever is already in  
9 place for those who are going to upgrade their  
10 equipment or replace equipment in the near future,  
11 and any new equipment that you buy, you know,  
12 certainly it's recommended that it be capable of  
13 defibrillating all ages.

14 MR. BLUM: There might be a floor, though, of  
15 these units where there are patients that exist  
16 below that floor. I'm not sure. So just for a point of  
17 accuracy, we might want to --

18 MR. WRONSKI: Yeah. I think that's recognized.  
19 And I mean, if we need to spell it out, we can, you  
20 know, and we can send a letter out regarding this.  
21 But I think that's well understood. You know.  
22 There's certain limitations to what machines can  
23 do.

24 MR. BLUM: As opposed to a manual unit on an

1 ALS unit where it can treat literally all patients.

2 MR. WRONSKI: Right. Right. Correct. The idea  
3 here was that there was discussion that the system  
4 may not, at this late date, in fact, have an AED  
5 available for their patients who need it. And so this  
6 was an attempt to impress once again that that's  
7 our expectation, that if you have a patient and  
8 you're transporting and treating them and it turns  
9 out they have cardiac arrest, that you've got a unit  
10 to do that. And there's a variety of ways to do that.  
11 I mean, potentially, you could even have a couple of  
12 ambulances at a scene and decide which one is  
13 going to transport the patient and have the AED in  
14 there. That's always a possibility. But typically  
15 what we were really looking at is if you're  
16 responding to an emergency call, your vehicle has  
17 to have an AED on it. If you've got a patient that  
18 you're transporting that needs an ambulance and  
19 that level of care, you've got an AED on board.  
20 That's the concept.

21 DR. MARSHALL: There was also some  
22 discussion about whether or not this would apply in  
23 inter-facility transports, and the answer was yes, it  
24 would. If you're taking a patient from the hospital

1 to home or nursing home or other facility for a test,  
2 you need to have that defibrillation capability on  
3 that transporting unit.

4 DR. FUNK: Mr. Lewis?

5 MR. LEWIS: Ironically, and all due respect,  
6 Madam Chair, while the Times Union is writing their  
7 article, EMS Systems In Trouble, I'm here appealing  
8 to this body yesterday -- to SEMAC, yesterday, for  
9 some consideration. When new innovative  
10 modalities are brought forth and we are expected --  
11 the United New York Ambulance Network members  
12 and all other ambulance providers are expected to  
13 jump and spend money that we don't have.

14 Let me first state, on behalf of UNYAN, the only  
15 group I can speak for, is we wholeheartedly believe  
16 that every responding 9-1-1 ambulance has to have  
17 a defibrillator. It has to have. If they're in the 9-1-1  
18 system and they're responding to provide care for  
19 emergency care, they have to have a defibrillator.  
20 Without question, we embrace that.

21 Our concern is that this motion drills down even  
22 deeper than that, and there are -- I'm told by a DOH  
23 staff member that there's up to a thousand  
24 ambulances in the State of New York that don't

1 have defibrillation capabilities.

2 I asked the question yesterday at SEMAC of Mr.  
3 Wronski, if he had any idea if we could quantify this  
4 need, and he clearly stated -- and I don't want to  
5 speak for you, sir -- that you could not. So there  
6 could be a thousand ambulances.

7 MR. WRONSKI: I have staff who sometimes  
8 don't share with me their thoughts. I also have staff  
9 who sometimes speak from their gut. I also have  
10 staff who -- I love them dearly, but I'm going to  
11 inquire where the evidence of this is, because I  
12 haven't seen it. The -- what -- potentially, you could  
13 have a thousand, yeah. I don't know how we would  
14 have that information. What I do know is that we  
15 have reports from the field that there, you know, --  
16 are percentages of ambulances -- not services,  
17 ambulances -- who may not have an AED on each of  
18 their vehicles. What that equates to, I can't say  
19 confidently.

20 What I will do is I will, this afternoon, speak to  
21 staff, find out what we have in black and white,  
22 prove-it-to-me terms, that we may have a thousand  
23 ambulances. And I'll look at that and report back to  
24 the council, Here's the actual numbers that we're

1 pretty confident on. You know.

2 Potentially, we could also do a survey and ask  
3 services to let us know, you know, what you find.  
4 But that really depends on does the service want to  
5 tell us. All right? They may not.

6 But clearly, and I'm very confident on this, there  
7 are vehicles that run in the system who may not  
8 have a defibrillator on them at the moment that  
9 they're operating.

10 MR. LEWIS: That's correct.

11 MR. WRONSKI: But I don't know the real  
12 number.

13 MR. LEWIS: I know there are -- my colleagues, I  
14 believe, will speak further after myself regarding  
15 that. But again, to be clear, UNYAN supports  
16 defibrillators on every responding -- 9-1-1 responding  
17 ambulance in the State of New York. We think it's  
18 essential. We think they shouldn't be responding or  
19 be allowed to respond without one.

20 But there are other issues, and we're going to  
21 be talking a little bit more about capnography and  
22 another expense, and some of us, most of our  
23 member companies have put CPAP on, which is a  
24 sixty to eighty-dollar cost to our member companies

1 for every patient we treat with CPAP that's not  
2 reimbursable. Capnography is not reimbursable.  
3 Use of these AEDs, while needed on all emergency  
4 ambulances, is not reimbursable.

5 And as I said at SEMAC, our small company, our  
6 small operation in Corning, New York, our fuel costs  
7 in the past eighteen months, twenty-four months,  
8 have gone from \$30,000 to \$80,000 and no way to  
9 surcharge like you do when you get your pizzas  
10 anymore. Some people are surcharging for delivery.  
11 We can't recover those costs. And we are -- UNYAN  
12 members across the state are the safety net for  
13 EMS in New York State, and I don't know how you  
14 can continue, while clinically I can't argue with you,  
15 to push these mandates down to us and expect us  
16 to stay in business, because reimbursement, again,  
17 for the record -- and there were several studies just  
18 done to prove that reimbursement for EMS-billed  
19 transports is 58 percent of what we bill. AAA just  
20 did that study and released it. Look it up. The  
21 American Ambulance Association just did that  
22 study. We are underpaid -- grossly underpaid for the  
23 services we provide. And while I agree clinically  
24 with what you're saying and what you're doing,

1 you're going to put businesses out of business in the  
2 State of New York if you don't quantify and qualify  
3 and give us an opportunity to budget and plan for  
4 these needed modalities.

5 Now, speaking -- I'm sure volunteer ambulance  
6 corps have budgets. Municipalities have budgets.  
7 And you can't, today, without justification, quickly  
8 move money to do anything. Sometimes it takes  
9 several years to move that kind of money.

10 So I ask you to, I believe, push this motion to  
11 systems and ask them to evaluate the need, first of  
12 all, and talk to the agencies that are delivering this  
13 care, that are still in business, what kind of a  
14 financial impact and how possible is it for you to  
15 fund this. We're not going to get any more money  
16 from third party payers, Medicare, Medicaid or  
17 HMOs. No. They're trying to slice the amount of  
18 money they're paying for ambulance services in the  
19 State of New York.

20 So you're creating, what I believe, an  
21 environment where companies that are on the  
22 bubble, and tell me companies that aren't on the  
23 bubble in this economic time. Ambulance services  
24 are on the bubble and you're going to push some of

1 them out of business. And as I said yesterday also,  
2 and I don't mean to be redundant, but I think it  
3 needs to be on the record that if companies like  
4 ours, Rural Metro, were to go out of business in a  
5 large municipality, municipalities can't afford to  
6 provide EMS. They have no money, either. The  
7 taxpayers are burdened beyond -- beyond compare  
8 in any other state, almost, now. So I ask you not to  
9 move rapidly.

10 And this motion wasn't even planned to be  
11 discussed on the floor yesterday, and all of a  
12 sudden, somebody makes a comment -- Oh, geez,  
13 there's not AEDs on every ambulance. So a motion  
14 is made and it's passed and expected that we will  
15 spend -- one of our member companies will spend a  
16 quarter of a million dollars to put AEDs on  
17 ambulances right now, I guess. Thanks.

18 DR. FUNK: Thank you. Mr. Lewis, your  
19 comments and sentiments are a representation of a  
20 large portion of the ambulance services in New York  
21 State. It's appreciated.

22 And just remembering a conversation that we  
23 had yesterday, while it did come up fairly suddenly,  
24 it was very unexpected that we discovered that

1 there were ambulances in the state that did not  
2 have the modality, the only modality in EMS, that  
3 has been a proven benefit to patients. So while the  
4 group certainly understood and heard from a  
5 number of people their concerns about cost, not  
6 only of the AEDs but of all these other modalities  
7 that continue to come up and will continue to come  
8 up, this one is a priority. And I know that you know  
9 that, and I know that all of us around the table  
10 understand that.

11 Maybe what we all need to do is all of us need  
12 to sit down and come up with that list of priorities  
13 and figure out where does the money need to be  
14 spent, because there's only a certain amount of  
15 money and it's not going up, and I think that we do  
16 understand that.

17 From the medical perspective, defibrillation is  
18 the only thing that research shows that EMS does  
19 and makes a difference with, outcome-wise. It's a  
20 small difference, but it makes a difference. So that  
21 has got to be a priority of some sort. And we do  
22 certainly need to pay attention to the cost  
23 implications of everything that we're looking at.  
24 We're going to get into that discussion once again,

1 with the next item, I'm certain.

2 If there are any other comments that introduce  
3 new -- new thoughts about the AED issue, can we  
4 have those? Otherwise -- apparently there are.  
5 Yes?

6 MR. SEROWIK: Just a point of clarification. Is  
7 the motion intended to apply to emergency  
8 ambulance service vehicles known as fly cars  
9 operated by ambulance services?

10 MR. MARSHALL: Transport or treat. So I mean,  
11 it wasn't specifically discussed, like the fly car  
12 issue, but -- that would require some more  
13 discussion.

14 MR. WRONSKI: The only fly cars that it affects  
15 are certified advanced life support fly cars. If I put  
16 an ALS fly car on the street and didn't put an AED in  
17 it, I would be ashamed. It does not affect BLS fly  
18 cars, because we don't certify them. It would be  
19 great, though, if you could. But we certainly don't  
20 certify them.

21 It only affects if you have ALS fly cars and you  
22 certify it as a department ALS fly car and put it in  
23 your system and you're using it that way. And, it  
24 should carry an AED. The -- at least that's my

1 understanding of any of the ALS fly cars.

2 DR. FUNK: Mr. O'Connor?

3 MR. O'CONNOR: Thank you. Just to kind of  
4 reiterate -- I'll try not to keep repeating these  
5 things, but I think what needs to be understood --  
6 and again, I agree with Mr. Lewis. I wholeheartedly  
7 endorse the idea of having AEDs available on  
8 emergency responding vehicles within 9-1-1  
9 systems and even ambulances that are assigned to  
10 mass gatherings where there would be groups of  
11 people.

12 However, there are a good portion of services  
13 who do inter-facility transports where 98 percent of  
14 the people are not at risk, even 100 percent of the  
15 time, are not at risk to go into cardiac arrest. And  
16 in order to mandate the units on those vehicles will  
17 be anything, for some operations, but a \$10,000 to  
18 \$250,000 expense.

19 There are states that I'm aware of that I have  
20 administrative responsibilities where it is a  
21 mandate to have AEDs on BLS units, and I can tell  
22 you without any hesitation that BLS transportation  
23 units in that particular state that I'm aware of have  
24 never used the AED on them, and they just tend to

1 take the money that could be used elsewhere (sic)  
2 -- other places.

3 And we started talking about, you know, EMS is  
4 in trouble, and it is in trouble for staffing reasons,  
5 for volunteer reasons, for cost for fuel. My service,  
6 in particular. We went from paying about \$7,500 a  
7 day for fuel to \$12,000 a day for fuel. Again,  
8 something that is not -- that is not reimbursable in  
9 any way, shape or form. None of us get goods or  
10 things delivered to our home without some sort of  
11 fuel surcharge. We are not an industry that is based  
12 on costs. We don't get reimbursed based on cost.  
13 We're reimbursed based on what -- what the payer  
14 wants to pay us.

15 I heard a physician tell me the best analogy of  
16 this. It's like going shopping and buying five bags of  
17 groceries, and they say to you, That will be \$100.  
18 And you say, You know what? I think it's worth  
19 about \$62. I'll give you \$62. That's what our  
20 business is like right now, 'cause we don't get paid  
21 for our costs.

22 The idea that -- again, Mr. Wronski, I'm a big  
23 supporter of yours and we go way back, but you sat  
24 there this morning and you kind of gave me

1 opportunities to kind of pick on things that you  
2 spoke -- not to pick on, but support the things you  
3 spoke on. The idea that your department has to  
4 look at reducing the fleet.

5 Do you not think that after 9/11 -- and those are  
6 the pictures that I brought with me -- that insurance  
7 rates did not skyrocket in the ambulance industry,  
8 going from \$8,000 a vehicle to an almost \$20,000 a  
9 vehicle for insurance rates? Not reimbursable.

10 The idea that we are talking about not having  
11 wonderful Danish and bagels here because we have  
12 to cut costs. At what point do we say, enough is  
13 enough? The private ambulance industry is set up  
14 so that when we do inter-facility transports, if that  
15 person is at any risk, the hospital, the facility, the  
16 doctor, moves that patient to an ALS vehicle which  
17 does have the capacity to move that patient safely,  
18 quickly, responsibly.

19 The idea of saying that every ambulance that is  
20 operating in this -- in this state has to have an AED  
21 is absurd right now, from a financial standpoint. I  
22 agree, 9-1-1, absolutely. Mass gatherings,  
23 absolutely. But when it comes to routine  
24 inter-facility transportation, I think it is a burden

1 that the state is going to put on services that is  
2 going to be problematic, that is going to be  
3 detrimental to the system, that is going to be  
4 detrimental to the safety net that we all provide.

5 So I'd ask that you proceed cautiously on this  
6 idea. Again, 9-1-1 trucks, vehicles, absolutely.  
7 There is no -- there is no reason not to have it. And  
8 I'm confident they have it.

9 The other point of saying that, Well, you're not  
10 going to need them for every unit that you have in  
11 your fleet. Well, then, what's going to happen to a  
12 service like mine or anybody here when you have to  
13 send a unit out because you're responding to a  
14 mutual aid event and that unit doesn't have the AED  
15 and somebody from the State Department is at the --  
16 is at the incident and says, Well, where's your AED?  
17 Well, this is the one unit that I didn't have to have it  
18 on.

19 It is just too gray. Support 100 percent. Put it  
20 on all 9-1-1 trucks. Put it on all mass gathering  
21 trucks. But I ask you, I implore you, do not make it  
22 a mandate to put it on all ambulances, all BLS  
23 ambulances in the state. I just think it's -- right  
24 now, it is something that the system cannot

1 support.

2 DR. FUNK: Mr. Delagi?

3 MR. DELAGI: I've been wrestling with this since  
4 yesterday. Let me apologize in advance if it sounds  
5 antagonistic, because it certainly is not, but I just  
6 want to offer a counter-thought.

7 We started to put AEDs in police cars in the  
8 early 1980s, and since that time, the technology has  
9 changed and AEDs have proliferated our  
10 communities where they have now become  
11 standard of care in the general population.

12 And I don't understand how we can be talking in  
13 2008, that there is an ambulance in this state that  
14 does not have an AED over the last twenty-four  
15 years. It just strikes me as very, very strange,  
16 because early defibrillation has come out as the  
17 standard of care going back decades. And to sit  
18 here in 2008 and understand that we still have  
19 ambulances that don't have AEDs, to me, I just don't  
20 get it. Where have we been for the last twenty-four  
21 years?

22 In addition to that, as far as the BLS  
23 ambulances go, you know, to me, it's  
24 unconscionable that a New York State certified EMS

1 provider would be in attendance with a patient in  
2 any fashion and not be able to provide rapid  
3 defibrillation, whatever the risk is. 'Cause  
4 everybody is at risk for sudden cardiac arrest. I just  
5 don't know what has happened over the last  
6 twenty-four years that we're having this discussion  
7 now related to fuel costs and things like that.  
8 Again, it's not antagonistic. I just -- I don't  
9 understand it.

10 MR. WRONSKI: If I could butt in here a little bit.  
11 One, I don't think this could be resolved at this table  
12 right now. I do think what is not -- is clear is that  
13 everybody agrees a patient who is in need needs  
14 the AED when it's needed. You don't have time to  
15 go call for it. So we agree, I think, that the basic  
16 tenants --

17 COURT REPORTER: I'm having trouble hearing  
18 you.

19 MR. WRONSKI: We agree with the basic  
20 tenants of the motion to have defibrillation  
21 available.

22 Two things, one a point of clarity. I used the  
23 term AED on ALS first response. It could be manual.  
24 All right? The key is the defibrillation availability. I

1 just want to clarify. You don't have to have your  
2 manual and then next to it, an AED. Okay?

3 But for, you know, the concerns raised by  
4 UNYAN, they're legitimate concerns. And I'm quite  
5 sure that they've -- any of the services who operate  
6 within the UNYAN framework make every effort to  
7 assure that patients who are going to need an AED  
8 have it in their system. And they do have, you  
9 know, large financial issues. The -- this issue has  
10 come up at a time when everybody's more financial  
11 issues because of the gas issue, and that's raised  
12 operating costs tremendously.

13 But I don't necessarily know that we'll resolve  
14 this here as far as, you know, when this will be, you  
15 know, implemented, if you will, by the state. I think  
16 everybody at this table has always expected that  
17 their, at this stage in the system, have AEDs  
18 available.

19 Will state surveyors, inspectors be looking at  
20 ambulances, starting after you vote, to count the  
21 defibrillators? The answer is no. One, the AED is  
22 not regulation. Okay? For us -- for my staff to go  
23 out and inspect an ambulance and say, You're  
24 deficient in this particular area, one of the key

1 things we have to have is an SPN regulation.

2 The other hook, obviously, is in protocol. And if  
3 we had a complaint, someone had a heart attack on  
4 an ambulance, no matter what kind, and you didn't  
5 have the ability to defibrillate, well, frankly, you're --  
6 you're in big trouble. And that's always existed  
7 because it is the standard of care. The defibrillator  
8 is the standard of care for a patient that goes into  
9 cardiac arrest, and we would push that point if that  
10 occurred.

11 What I might ask is that we consider the  
12 concerns that we've heard here. In -- at the  
13 December meeting, I'll bring back more concrete  
14 information about, you know, what I can find out on,  
15 really, how many ambulances are out there. Maybe  
16 I'll find out what state staffer thinks they know and  
17 come up with that detailed information. But I have  
18 a feeling I don't have documentary evidence of that,  
19 and I'll -- we'll have to do that, and we will assign  
20 that to that state staffer.

21 The -- but it's not -- it's not a -- and I apologize. I  
22 don't mean to make this humorous. It's a very  
23 serious issue. It's a serious issue for the patient.  
24 We all agree with that. Everybody at this table

1 does. But it's a serious issue in operation, as well.  
2 And what does that mean?

3 So we'll look at that and bring that information  
4 back, but certainly, if there is a need for more  
5 conversation, I'm not -- it's up to the Chair how far  
6 she wants to continue to keep this open.

7 DR. FUNK: Is it possible that we have to have  
8 more information to be able to have a vote on this  
9 issue?

10 SPEAKERS: Yes. Yes. Yes.

11 SPEAKER: Madam Chair, motion to the table.

12 SPEAKER: Motion to the table.

13 DR. FUNK: And there's a second motion to the  
14 table. All those in favor of tabling this until  
15 December when we have further information?

16 SPEAKERS: Ayes. Ayes. Ayes.

17 DR. FUNK: Against?

18 SPEAKERS: Ayes. Ayes. Ayes.

19 DR. FUNK: Abstain? So three against.  
20 Abstain? Okay. It sounds like we're tabling it until  
21 we have more information in December.

22 Why don't we go ahead and take a ten-minute  
23 break. I'm seeing a lot of people jump up and down  
24 and wiggle around. Ten minutes, right back here.

1 (Whereupon, a brief recess was taken.)

2 DR. FUNK: So am I to understand that the  
3 medical standards report is done?

4 DR. MARSHALL: No, ma'am.

5 DR. FUNK: Then why don't we go ahead and  
6 finish that up.

7 DR. MARSHALL: Medical standards has some  
8 other information to bring forward, and I know that  
9 everyone is eagerly awaiting a discussion on wave  
10 form capnography but I'll take the easy stuff first. I  
11 always say that and it never turns out that easy, but  
12 -- and I apologize for the amount of information, but  
13 this is from two meetings, because at the last  
14 SEMAC, we had to postpone stuff.

15 Policy 95-06 was a policy on pediatric  
16 intubation training, and medical standards and  
17 SEMAC discussed it and decided not to change it --  
18 make any changes to that policy, so that will remain  
19 the same.

20 Medical standards was asked to develop  
21 recommendations on what procedures can or should  
22 be done in the back of a moving ambulance while  
23 the provider is belted or unbelted. So we have  
24 taken the list of skills that are in the curriculum that

1 can be done in an ambulance or possibly in an  
2 ambulance transporting a patient and we've  
3 addressed each in terms of whether it should be  
4 done, should not be done, or should be done with  
5 caution in a moving vehicle. And we'll distribute  
6 that for further discussion in December.

7 We're also working on the state EMS formulary.  
8 We've requested that all regions submit their  
9 formulary so we that can put it in a grid and come  
10 up with a comprehensive list of medications that  
11 are being used in New York State in a pre-hospital  
12 setting.

13 We also discussed -- we reminded REMACs and  
14 region councils on protocol submission that it be  
15 done timely, so we could have a group of individuals  
16 really go through the protocols intensely prior to  
17 medical standards, to help us move that along.

18 Okay.

19 Back in 2002, SEMAC put out an advisory  
20 related to the secondary confirmation of  
21 endotracheal tube placement. There was quite a bit  
22 of discussion over the past two meetings regarding  
23 this advisory. Actually, since December of '07,  
24 there's been quite a few discussions regarding this

1 and the use of wave form capnography in patients  
2 who are intubated.

3 Just a little history on the discussion, and if  
4 anyone else remembers anything, please feel free to  
5 take over.

6 Originally, we had -- well, we discussed wave  
7 form capnography as a technology that's available  
8 to make sure that when we intubate patients, that  
9 we know that the tube is in the right place. The  
10 original discussion was that wave form  
11 capnography should be used in a pre-hospital  
12 setting in all patients who were being intubated  
13 who were not in arrest. Okay? So if you had a  
14 patient who was alive and you wanted to intubate  
15 them for whatever protocol it called for, you needed  
16 to have wave form capnography in addition to the  
17 other secondary confirmation devices, to make sure  
18 that the tube was in the correct place. Also, that  
19 was expanded to include all pediatric patients who  
20 were being intubated in the pre-hospital setting.

21 That discussion continued over the last  
22 meeting and with the change in how we interpret  
23 the term "intubation" to be only an endotracheal  
24 tube.

1           In terms of the advisory that's going to be going  
2 to the Commissioner, we discussed that only those  
3 patients who are -- all patients who are going to be  
4 intubated using an endotracheal tube in a  
5 pre-hospital setting would need to have wave form  
6 capnography initially and continuously until the  
7 patient arrives at the hospital. The -- both medical  
8 standards and SEMAC felt very strongly about this,  
9 and we wanted to make sure that we do what's  
10 right for the patients.

11           Other discussions had to do with some  
12 comments that had been made and related to  
13 whether or not we were going to require it in  
14 patients who were post-arrest. If you respond to  
15 the scene of a cardiac arrest, you intubate the  
16 patient. And then those patients, we also felt,  
17 needed to have wave form capnography, because in  
18 order to get return of spontaneous circulation, you  
19 want to make sure the tube remains in the right  
20 place during transport until they get to the hospital,  
21 and then we want the hospital to make sure the  
22 tube is in the right place.

23           In the actual advisory, the original one had -- it  
24 said in all out-of-hospital adult patients and

1 pediatric patients, it will now read that all patients  
2 who are intubated with an endotracheal tube.

3 There was some discussion regarding agencies  
4 that may not be able to -- and I'm getting into the  
5 operational aspects, and I'm not an operations  
6 person, so please excuse me if I mess it up. But  
7 agencies that will not have the capability of  
8 providing this technology by January 1, 2009, which  
9 was the implementation date that was decided on --  
10 and this goes back on December of '07, actually, I  
11 believe. If not, please correct me. And what both  
12 medical standards and SEMAC discussed was that --  
13 and they felt very strongly about this -- that you  
14 really want to make sure that an endotracheal tube  
15 is in the right place, and if you don't have the  
16 capability to do wave form capnography January 1,  
17 2009, you should not be using an endotracheal tube  
18 as an advanced airway tool. There are other  
19 options available under advanced airway that you  
20 can use, but they felt strongly that an endotracheal  
21 tube absolutely requires wave form capnography.

22 So it's not -- and there was discussion about not  
23 wanting to prevent services from providing ALS  
24 services, not trying to put an ALS service back to a

1 BLS service, but realizing that there are other  
2 options for managing a patient's airway, whether  
3 it's a King airway or one of the others that are  
4 available commercially. Those are the things that  
5 the committee discussed.

6 And so this advisory -- let me just back up -- so  
7 the advisory which replaces the original advisory,  
8 which was from 2002, will apply to all patients who  
9 have an endotracheal tube in the pre-hospital  
10 setting will be required to have wave form  
11 capnography.

12 And there was -- I think I'll stop there and sit  
13 back.

14 DR. FUNK: Seeing no discussion -- we -- in the  
15 interest of assuring that we have time for all  
16 committee reports, I want to recognize that  
17 probably every one of you around the table has  
18 comments on this. The medical standards  
19 committee and the SEMAC made it very, very clear  
20 that this is the standard of care. It's incredibly  
21 important, and they were not willing to waiver on  
22 what they considered to be the standard of care,  
23 which is wave form capnography for all intubated  
24 patients. There are other alternatives, if you are

1       unable -- and we recognize that some services,  
2       given the timing and budgetary cycles, that may not  
3       be able to put this technology into place. There are  
4       other very acceptable devices to use other than  
5       endotracheal tubes. We all verbalized around the  
6       table an appreciation for the cost issues, the  
7       budgetary cycle issues, the concerns about how  
8       this process has gone through. The bottom line is  
9       we have an advisory that's been approved by the  
10      SEMAC that's coming here, for your information.

11             Certainly, your discussion is welcome to a  
12      limited extent. We do have the rest of the meeting  
13      to get on with. And any information that you have  
14      that you feel needs to be brought forward to the  
15      Commissioner, together with this advisory, would be  
16      welcome at this time. Yes.

17             MR. REISNER: Walt Reisner, Southwest  
18      Regional EMS Council.

19             I appreciate the SEMAC's intentions; however,  
20      the budgetary issues, I think, are something that my  
21      council is very concerned about.

22             Our REMAC had discussions about  
23      implementation at the REMAC level. It was decided  
24      that a timeframe to implement would be the right

1 approach. Clearly, the SEMAC, in December of  
2 2007, thought that a one-year window for  
3 implementation was the right approach, because  
4 that's what they started with.

5 So I think that as with the AED being now and  
6 the wave form capnography being January 1, I have  
7 to ask the question: Is there a disconnect between  
8 operations and medical standards? I would say  
9 procedurally, if there are operational implications,  
10 these things should be referred to the systems  
11 committee, because overall, these are EMS  
12 systems' issues. It would be great if every hospital  
13 had a cardiac cath lab twenty-four hours a day, but  
14 because of operational issues, it's not practical, and  
15 the priorities are weighed and decisions are made  
16 based on what is practical in today's economic  
17 times. That's the missing link here.

18 And I would suggest that when medical  
19 standards and SEMAC come up with something that  
20 has operational implications, it go to the systems  
21 committee and let's look at the whole thing.

22 Very personally, my squad will have to either  
23 not do intubations on six of our trucks or use a  
24 secondary device for primary -- in lieu of the primary

1 device, because there is no way that I'm going to  
2 come up with that kind of money between now and  
3 January 1st. It's something we could budget for and  
4 purchase, given the appropriate lead time, but I just  
5 -- I just think there's a disconnect between SEMAC  
6 and operations. With all due respect, I appreciate  
7 the medicine, but there has to be given  
8 consideration for planning and budgets.

9 I know the volunteer cycles in fire in our  
10 communities -- we're in mid-budget cycle. These  
11 agencies need to get budgeted. They're not  
12 resisting getting it, but they're saying, Put it within  
13 our budget cycles and give us appropriate lead time.

14 And in the meantime, let the REMAC say, If  
15 you're going to use -- if you're not going to have this,  
16 use a secondary device or use good practice now.  
17 Dr. Daily said it -- we're not imputing the reputation  
18 of the EMTs who can't get a tube in. It's when we  
19 move a patient that the tubes get dislodged. Use  
20 standard of care, the old-fashioned standard of care.  
21 After you move a patient, you do a check and a  
22 recheck with a secondary confirmation device.  
23 There's more than one right way to do it and get to  
24 the right answer, so why are we in this rush? We

1 got the old state mandate crank going, unfunded  
2 mandate machine yesterday. What is the rush? We  
3 don't have evidence that people are dying. We have  
4 evidence that there is a better way to do things, and  
5 that can happen in a stepped approach.

6 I ask for that reason to prevail as we do  
7 business here. Thank you.

8 DR. FUNK: Mr. Zeek? Thank you, by the way.

9 MR. ZEEK: I would agree with -- can you hear  
10 me? Okay. I would agree with Mr. Reisner, and I  
11 would like to see some mechanism to involve the  
12 REMACs and perhaps add the cover letter that you  
13 mentioned yesterday, too. Have the REMACs  
14 monitor the implementation of this advisory, and for  
15 those services that can, to assist them in making a  
16 plan to implement it as soon as practicable within  
17 the fiscal restraints that they face. I think that  
18 makes some sense.

19 MR. FAETH: I'm in support of the movement  
20 from the Department towards wave form  
21 capnography, its implementation and the adoption  
22 of that.

23 COURT REPORTER: I need you to speak into  
24 the microphone. I can't hear you.

1 MR. FAETH: Oh, I'm sorry. I said I'm in favor of  
2 the wave form capnography movement and  
3 adoption. I don't really have a comment on its  
4 mandatory start date, but to affirm the amendment,  
5 if I could possibly suggest -- I think it only addresses  
6 half the issue, and as Walt had mentioned in regards  
7 to displacement, as far as misplacement, maybe the  
8 medical advisory group or SEMAC can possibly put  
9 an addendum to this advisory listing possibly the  
10 best practices of how to secure an ET tube and its  
11 follow-up, I think, would be very important in  
12 addressing a lot of the problem issues that are  
13 occurring out in the field.

14 Many -- many, many organizations are using  
15 tape to secure these devices. Many organizations  
16 are not utilizing C-collars when they're moving  
17 patients from their residence to the ambulance to  
18 the stretcher to the hospital stretcher, and -- and  
19 you know, I strongly believe that a lot of these  
20 problems that are occurring with ET tubes is a  
21 displacement and not a misplacement.

22 So if that could possibly be done, I'd greatly  
23 appreciate that.

24 DR. FUNK: We can certainly bring that back to

1 the -- to the committee as an additional, but I don't  
2 know that this is in a position to be changed at this  
3 point. But we can bring that back for discussion.  
4 Yes?

5 MR. WEDGE: There is an advisory that is going  
6 to be issued. I'd like know what the timeline for  
7 issuance is going to be. Once -- if it's approved  
8 here, does it not need to go to the Commissioner for  
9 approval, which is going to delay again the mailing  
10 to the REMACs and the other organizations, which is  
11 going to again reduce the amount of time that we  
12 have something in writing which has to be  
13 implemented than if we had done this like six  
14 months ago and we got something out?

15 I'm having a real problem telling people that  
16 they have to spend money for things that they have  
17 not budgeted, and I know that you've heard that  
18 many times, but that seems to be the issue. The  
19 medicine is fine. It's the implementation timeframe  
20 that I think is going to cause many people problems.

21 MR. WRONSKI: Just to answer that question,  
22 the -- it does go to the Commissioner. I'll have this  
23 to the Commissioner with comments such as your  
24 own, Mr. Wedge, so that the Commissioner

1 understands what the primary concern is on its  
2 implementation, so the Commissioner can modify  
3 the advisory and so -- you know -- advise the  
4 SEMAC.

5 The -- I can't say exactly what will happen, but  
6 part of the reason for the discussion is to hear your  
7 issues, but I'll have this to the Commissioner next  
8 week. I do not know when the Commissioner will  
9 respond to me. That could be in days or it could be  
10 in a couple of weeks, at which point we'd  
11 immediately get it out.

12 But -- you know -- really, part of the reason to  
13 have this discussion here is that our process has  
14 been bring the SEMAC advisories to this body for  
15 comment so if there are issues that this body has,  
16 we can consider them and I can share them with  
17 the Commissioner.

18 So I can't give you an exact answer. I will tell  
19 you absolutely the Commissioner will look at, you  
20 know, the issues raised and do we have enough  
21 time to make this happen. That certainly will be on  
22 the table.

23 DR. FUNK: I'm going to take one more  
24 comment, if that's okay. We appreciate certainly all

1 the comments. I know they're all very important.  
2 We've heard a lot of this at the -- at medical  
3 standards and at SEMAC.

4 MR. FARAONE: Just -- has anybody asked the  
5 question to Physio-Control? It's six, eight months to  
6 get an AED nowadays. Can they even put these  
7 things out by January 1? Unless they have a  
8 warehouse full of these capnographies, it's not  
9 going to happen.

10 DR. FUNK: I certainly have not, but it's  
11 certainly worth starting to make phone calls now,  
12 and there's more than one -- more than one  
13 production department and more than one brand.

14 MR. WRONSKI: If I could just comment? One --  
15 and that certainly is a concern. But for everyone at  
16 this table, for all the councils and all members in  
17 the audience, the one thing to know is this is going  
18 to happen. All right? Capnography is the standard  
19 of care. That is going to happen. Whether it  
20 happens, you know, as a mandate on January 1 is  
21 an open question for consideration by the  
22 Department. But there is absolutely no doubt that  
23 we're moving in this direction and there was really  
24 no doubt back in December. That was a message

1 that was sent very clearly by the SEMAC back then,  
2 by all the conversations, that this is the standard of  
3 care and begin. So there was an expectation that  
4 even though, you know, we had not sent out a letter  
5 on this because we didn't have a final vote and  
6 quorum to finalize this, that the information had  
7 been out, been on the web, gone to your councils so  
8 that you could prepare yourself for this. And there  
9 is always an expectation that regional delegates  
10 will go back and say, Listen. This is a big issue.  
11 You know. We should begin, in the region, to advise  
12 people that this is on the way. Whether or not it  
13 turned out to be January 1st or maybe June 1st of  
14 next year, is immaterial.

15 In the future, any of these things -- when it's  
16 very clear that we're moving in a certain direction,  
17 start talking at your regional level and say, This is  
18 going to happen. You know. Start making  
19 preparations. But at the same time, absolutely hear  
20 Mr. Wedge and others, that there are those who  
21 have not been prepared for this, and there's a  
22 concern about January 1st, so that was on the  
23 table. It'll be shared with the Commissioner, and  
24 we'll let you know as soon as I have a decision.

1 MR. HASSETT: A point of order. The -- this  
2 body did, at its last meeting, pass a motion, and  
3 that was for wave form capnography. However, we  
4 also, in that same motion, included the -- the  
5 authority for the REMSCOs -- or the REMACs to grant  
6 the waiver with a corrective action plan. And while  
7 the SEMAC is looking to circumvent that motion by  
8 going through an advisory to the Commissioner, I  
9 would ask Mr. Wronski that since that was a motion  
10 approved by this body, that that information be  
11 brought forward to the Commissioner, as well, that  
12 this body has recommended that the regions be  
13 given the authority to grant waivers in extenuating  
14 circumstances.

15 MR. WRONSKI: Yeah. Actually, I was going to  
16 do that, but thank you for bringing it up. That will  
17 be also sent up.

18 DR. MARSHALL: Dr. Funk?

19 DR. FUNK: Please.

20 DR. MARSHALL: Just one quick comment about  
21 this, so that those around the table and in the  
22 audience don't think that SEMAC sat around  
23 yesterday and just set this date arbitrarily.

24 There was quite a bit of discussion, even back

1 in May, and I believe the original motion was that  
2 the regional medical advisory committees have the  
3 ability to extend the date if a service could not meet  
4 the January 1st date.

5 So that was the original motion at medical  
6 standards and SEMAC. And that was discussed  
7 quite a bit, for those of you especially who weren't  
8 here in May or yesterday. But after much  
9 discussion, it was felt, from a medical standpoint,  
10 that, you know, this technology is really important  
11 for our patients in the pre-hospital setting.

12 So it's not that we don't think about the  
13 operational issues or how to operationalize (sic) a  
14 medical standard. We do, and we consider it very  
15 carefully. So just to let you know that.

16 DR. FUNK: The rest of your report?

17 DR. MARSHALL: I apologize Madam Chairman,  
18 but that is my report.

19 DR. FUNK: Believe it or not, we have a few  
20 other committees to get through. Perhaps a few  
21 items from the finance committee.

22 MR. MCEVOY: The finance committee, Phyllis  
23 Ellis, the Chair, is unable to be here because of  
24 illness in her family. The finance committee met

1 this morning and has been working through the  
2 summer on the proposed budget for EMS for  
3 2009/2010, and that went out a few weeks ago on  
4 the SEMSCO list server, and I think the members at  
5 the table have been given printed copies of it this  
6 morning.

7 So that comes forward as a seconded motion  
8 from the committee. And for the year 2009/2010,  
9 the total budget request which will be transmitted  
10 by the Commissioner to the Governor will be  
11 \$23,596,180.

12 In the document, we again make note, as we  
13 have for the last couple years, of a shortfall in the  
14 funding for the program agencies in the EMS  
15 councils, which has remained at 3.45 million dollars  
16 since 1999 without any increase. And we're  
17 currently, in this budget proposal, asking for 5.83,  
18 which has a difference of what they've been funded  
19 of about 2.38 million dollars. And I just figured that  
20 I would make a note of that on the record, because  
21 that's been a persistent issue that we've identified  
22 in the budget process.

23 So that figure comes forward -- what you have  
24 in front of you comes forward from the finance

1 committee as a seconded motion.

2 DR. FUNK: Is there any discussion on proposed  
3 budget? A roll call vote on this, please.

4 (Roll call vote taken.)

5 DR. FUNK: Thank you to the finance committee  
6 for all of that work over the summertime. Do you  
7 have anything else?

8 MR. MCEVOY: The only other item that I'll  
9 mention just for informational purposes is we've put  
10 aside a project that we had started working on prior  
11 to this budget process, which we began in March,  
12 looking at the funding for courses and the allocation  
13 of those dollars amongst the different training  
14 levels, and we're going to pick that project back up  
15 again in December.

16 There was a little bit of discussion at the  
17 meeting this morning about the urgency of that as it  
18 pertains to some of the levels of funding across the  
19 state and the difficulties that core sponsors are  
20 having with actually being able to run the courses  
21 at those various levels.

22 And the topic that came up this morning was  
23 the ability to perhaps allow sponsors to charge  
24 students in addition to what the state

1 reimbursement is. And between now and  
2 December, some of the members of the committee  
3 and Mr. Wronski and myself will have a little  
4 discussion about that, so that we can report back to  
5 the committee in December about the feasibility of  
6 doing such an adjustment in the way that the  
7 funding is done.

8 And then, in December, we will begin to work  
9 with the data that we've collected over the course  
10 of the year from core sponsors and from the bureau,  
11 actually taking a closer look at that funding.

12 That's the end of my report, unless there's any  
13 questions.

14 DR. FUNK: Thank you. Any questions? Thank  
15 you. Next report. If I can have Ms. Fults with  
16 education and training?

17 MS. FULTS: Education and training met  
18 yesterday and I have a short report for you today.

19 There is a new policy statement that came out,  
20 08-05, which has done -- the instructor certification.  
21 And in this advisory -- excuse me -- in this policy, it  
22 has removed, under the CIC recertification portion  
23 of it, where a CIC no longer has to be actively  
24 running on an ambulance or providing hands-on care

1 to patients. Remember we had talked about that.  
2 We do bring that forward. And it's right here, if  
3 anyone wants to see it. So -- and to let you know,  
4 this is just for CIC recertification, not CICs original  
5 certification.

6 There will be a new policy coming out for -- it's  
7 in draft form now, for the military extension. They  
8 want -- it's going to include six months following  
9 their release from military service. So that's going  
10 to be added to that.

11 Prescreening for your CLI courses, those of you  
12 that are especially core sponsored, when you want  
13 to set-up a prescreen, you do have to apply for a  
14 course number, and the second thing is that you  
15 must use regional faculty to conduct your  
16 prescreens.

17 National registry. This, we want to bring  
18 forward to see if STAC could research and comment  
19 on that, but national registry is changing a  
20 recommendation for controlling hemorrhage in  
21 out-of-hospital environment, and they say there's no  
22 research that supports use of elevation or pressure  
23 points to control hemorrhage. So their  
24 recommendation is if external bleeding from an

1 extremity that cannot be controlled by pressure,  
2 application of a tourniquet is the reasonable next  
3 step. And this is what national registry has to do.  
4 So is there anybody here from STAC?

5 MS. GEIGER: Thank you. Dr. Funk, if you could  
6 just translate it to us and we'll be glad to bring it to  
7 STAC, which, Ms. Fults, meets next week.

8 MS. FULTS: Okay. Good.

9 MS. GEIGER: And we'll ask that they take it  
10 under review and advisement.

11 MS. FULTS: Thank you. The educational  
12 standards, the last -- well, the final draft of the  
13 educational standards has come out, final draft,  
14 version 1.1. For those of you that would like to  
15 review these national EMS education standards -- I  
16 think I told you this in May, but I'll tell you again --  
17 you can go to [www.nemses.org](http://www.nemses.org) and go into that site  
18 and scroll down and hit "educational standards" and  
19 you can click onto that.

20 We have formed a TAG that is looking at all the  
21 levels -- EMR, basic, advanced and paramedic.  
22 They're looking at each of those -- they're going into  
23 those levels, compare their instructional guidelines  
24 to ours, and see where we are with what they're

1 proposing to come out and what we add possibly or  
2 delete. So we do have a TAG that will be working  
3 on that.

4 TAGs met yesterday and the CLI curriculum  
5 TAG, who's been working on adding the skills  
6 portion back into the CLI curriculum, they're still  
7 working on that and hopefully will have something  
8 for us by the end of the year. Most of our TAGs have  
9 completed their work. I'm going to ask Andy  
10 LaMarca to speak on the specialty care transport  
11 TAG.

12 MR. LAMARCA: Thank you, Debbie. Specialty  
13 care transport TAG has completed about eighty  
14 percent of their assigned tasks as far as developing  
15 educational standards for a potential SCT training  
16 program, but during the course of those meetings,  
17 and that was up until our last council meeting, we  
18 had uncovered a couple of issues that certainly did  
19 bear on the future of the SCT training programs.

20 We did bring that at the time to the Chair and to  
21 Mr. Wronski in executive session, because we felt  
22 certain issues needed to be addressed which were  
23 beyond the scope of the TAG, issues such as who  
24 would actually be able to run this program. It was

1 initially thought that paramedic core sponsors  
2 probably are the most likely, you know, repository  
3 for this, although there's some reluctance on their  
4 part to take on a program that has no funding  
5 stream for it. They would have to do the research  
6 and development portion of creating the actual  
7 curriculum. So there is a lot of background work to  
8 be done.

9 There is currently no funding. There's no  
10 funding planned for this. There is also no  
11 certification level for this program, which brought  
12 up issues dealing with reciprocity and how do we  
13 know that a SCT paramedic trained in Buffalo is the  
14 same as one in Long Island is the same as one in  
15 New York City.

16 And again, mostly from information provided by  
17 the paramedic core sponsors, they're having an  
18 existing problem obtaining clinical rotation or  
19 clinical sites for the paramedic level skills, again,  
20 during the hospital rotations, looking at the SCT  
21 program, which would probably definitely include  
22 skills above the level of a current paramedic. It  
23 highlighted the fact that, you know, that issue  
24 would be crystalized here.

1           The paramedic courses are, right now, using  
2           sim labs, really, to get most of their clinical work --  
3           well, I say clinical -- experience in intubations and  
4           other skills.

5           So we did ask the department at the May  
6           meeting, and we asked again last night at executive  
7           session, for there to be a -- some form of meeting or  
8           task force for the stakeholders which would include  
9           not just the Department of Health for this bureau,  
10          but also, the hospital division, possibly the  
11          Department of Education, the hospital associations  
12          and the educators, to resolve some of these issue  
13          so we can decide if we can move this project  
14          forward.

15          But without funding, without certification,  
16          without a lot of these issues answered, the  
17          committee or the TAG is not going to put a  
18          document together that will sit on the shelf. And  
19          we've left that with executive last night.

20          MS. FULTS: Thanks, Andy. Any questions for  
21          Andy on the SCT? Okay.

22          Just a couple other things. Also, on the  
23          educational standards, they do not have a CC level,  
24          and we want everybody to know that New York

1 State is not getting rid of our critical care level.  
2 Okay? So New York State's critical care level will  
3 remain.

4 The other thing on the educational standards,  
5 they're due to NHTSA by October 2008, and then  
6 NHTSA will release them within six months to one  
7 year, somewhere around May of 2009.

8 And I think I covered this back in May, but  
9 again, the publishers are going to need twelve to  
10 fifteen months to revise their textbooks. So the  
11 summer of 2010 will be the earliest when we see  
12 the textbooks come out.

13 And then the American Heart Association  
14 standards change in 2010, so there's more to see on  
15 the educational standards.

16 The last thing is national registry. Again, I just  
17 want to remind everybody as of 2012, national  
18 registry will require paramedic program  
19 accreditation in order for paramedics to take the  
20 national registry exam. That's 2012. And of 500 to  
21 600 paramedic programs across the nation that  
22 need accreditation, only 250 have received them at  
23 the time.

24 Does anybody have any questions for me?

1 That's the end of my report.

2 DR. FUNK: Thank you. Next up I have peer.  
3 Mr. Faeth?

4 MR. FAETH: Thank you, Madam Chair.

5 Peer comes to the body today with no seconded  
6 motions.

7 Donna provided the staff report, that states that  
8 Vital Signs is on track and will be held in Buffalo  
9 from October 2nd to the 5th. Hotels are going fast,  
10 so if you intend on attending Vital Signs this year,  
11 please get your registrations in and submit for your  
12 hotels. You can even submit the registrations here.  
13 Booklets are outside and you can fill that out and  
14 get that in and save yourself a stamp.

15 I'm passing around a sign-up sheet for the  
16 SEMSCO booth. Please, if you can take out your  
17 calendars, I kind of warned you guys I was going to  
18 be hitting you with this today. I'd appreciate it.  
19 Even if -- you see that they're all one and a half hour  
20 slots, even if -- and I have two slots for each one  
21 and a half hour block. But even if there are two  
22 people already listed, and that's a time slot that you  
23 can do, put your name down and then we could even  
24 break it up further, where you have 45 minutes for

1 one person and 45 minutes for another. You know.  
2 The more people that sign up for this, the less of a  
3 burden this will be on any one individual. So we  
4 greatly appreciate it. Also, as an added incentive, if  
5 you are a vetted member of SEMSCO, you do have  
6 your registration waiver -- fee waived -- waived --  
7 I'm sorry -- if you participate in this. So don't do it  
8 for that reason, but we greatly appreciate it.

9 Also, we spoke about how the booth will be set  
10 up. We have a photo display of the committees, as  
11 you know. I've been irritating all of you with taking  
12 your photos. I have all the photos that I took in the  
13 last meeting. If you have not seen it yet -- I've been  
14 trying to catch everybody that I can -- and you want  
15 to take a look at your photo and see whether or not  
16 you approve of it. If you don't approve of it, I'd be  
17 more than happy to take a second photo. There's  
18 no problem with that. I've also taken photos of all  
19 the committees. We're going to set up a display  
20 board basically introducing the different regions to  
21 who the representatives are here at SEMSCO and  
22 giving them an idea of what we do and who we are.  
23 Okay? So come see me if I haven't taken your  
24 photo, definitely, or if you want a retake. Okay?

1           Also, Donna asked me to remind all of you that  
2           December 1st is the deadline for submissions for  
3           the State memorial. Please do not wait until the  
4           last minute. I hope that none of you have  
5           submissions, but if you do, please get that in. This  
6           way, they can be properly recognized for the  
7           sacrifices that they made. We'd greatly appreciate  
8           that.

9           The peer committee also met over the summer,  
10          on August 14th -- we had a -- very good attendance.  
11          I appreciate the participation of all the members, in  
12          order to do the arduous task of selecting one winner  
13          from the stack of nominees that was submitted by  
14          the REMSCOs for the State awards.

15          I want to thank all of the REMSCOs for  
16          recognizing the people in the regions and making  
17          these submissions. Unfortunately, only one  
18          REMSCO, southern tier, again made no submissions.  
19          So I hope that that gets changed. And we're going  
20          to try and make a little more awareness to the  
21          actual providers out there that if they see  
22          something that is notable and worth recognizing or  
23          there is an individual amongst them that they feel  
24          really should be recognized that they also do the

1 paperwork. We'll give them the venue to do that,  
2 and then submit that to their REMSCOs, so there'll  
3 be no excuses for not getting submissions in.

4 The winners are as follows: The Basic Life  
5 Support Provider of the Year goes to Falene "Fox"  
6 Grass of the Southwestern REMSCO. The ALS  
7 Provider of the Year is going to Daniel R. Parr from  
8 the Finger Lakes REMSCO. EMS Agency of the Year  
9 goes to Thousand Island Emergency Rescue  
10 Services, also better known as TIERS from North  
11 Country REMSCO. Harriet C. Weber Leadership  
12 Award goes to Mr. Douglas Baker from the  
13 Wyoming-Erie REMSCO. Educator of Excellence  
14 goes to our very own William J. Little from the  
15 Finger Lakes REMSCO. EMS Communications  
16 Specialist of the Year goes to Mr. Anthony Noche  
17 from the Central New York REMSCO. The  
18 Registered Nurse of the Year goes to Miss Cheryl  
19 Manasier from Hudson Valley REMSCO. And the  
20 Physician of Excellence goes to Dr. Martin C.  
21 Masarech from the Susquehanna REMSCO.  
22 Congratulations to all of them and also to all the  
23 people that were nominees. I wish we could  
24 acknowledge all of them, but we don't have the

1 resources to do that. There are a lot of people  
2 doing good work out there and we want to thank  
3 them for that.

4 MR. REISNER: A point of clarification. Mr. Parr  
5 is from the Southwest region rather than the Finger  
6 Lakes region. Perhaps that first one was from  
7 Finger Lakes.

8 MR. FAETH: Mr. Parr. Okay. According to the  
9 submission sheet, that's what they put him down,  
10 but I'll have that corrected. Thank you.

11 Okay. Moving right along. I know you've heard  
12 me speak about the dos and don'ts placard that we  
13 were working on that would be similar to the CPR  
14 placard that's up in restaurants. It is finally  
15 finished, and I want to thank the peer group for  
16 getting together and working on this, and the  
17 Department of Health graphic staff. You probably  
18 saw copies of this outside. I'm going to pass this  
19 around just for your edification. Now, we're -- they  
20 are producing them here at the Department of  
21 Health. If you want copies of this for your agency, I  
22 believe you can see Donna or Valerie and they will  
23 make that happen for you. And we are also still  
24 looking at how we're also going to distribute this.

1 But thank you to everybody that participated in that.

2 In children's play, we got a lot of work done on  
3 that. We're moving right along, and we hope to  
4 actually have a tangible product that we'll be able  
5 to produce for all of you come the December  
6 meeting. I hope you can hold me to my word on  
7 that. We're going to try.

8 And that concludes my report.

9 DR. FUNK: Questions? Thank you. That was a  
10 lot of good news for a change. Evaluation, Mr.  
11 Delagi.

12 MR. DELAGI: Thanks, Dr. Funk. Evaluation  
13 committee met yesterday. Staff has the attendance  
14 sheet and there are no motions to bring forward  
15 today.

16 We had a productive summer. We also had a  
17 work-in session yesterday. On behalf of Dr.  
18 Kauffman and our entire committee, we would like  
19 to thank our medical TAG representatives who  
20 came and joined us yesterday as we began the  
21 process of reviewing and collating the data that we  
22 received so far for the air medical survey study on  
23 helicopter request appropriateness.

24 We've identified our goals as we continue that

1 project, in identifying the flight programs that did  
2 not respond, in reviewing the data for answers to  
3 the specific questions that the study was designed  
4 to collect, to provide feedback to air medical  
5 carriers and their respective program agencies and  
6 REMSCOs, and finally, to revisit in the future based  
7 on the results that we do find. This will turn out to  
8 be a sample study, where the committee will work  
9 with their medical TAG group between now and  
10 December to generate a draft report which we hope  
11 to have ready for you at the December meeting for  
12 review in draft form.

13 Miss Geiger was on hand to provide the bureau  
14 staff report, and during that report, we learned that  
15 currently there is no new information on the state's  
16 quest to become NEMSES compliant. The State of  
17 New York, despite some federal reports to the  
18 contrary, has not --

19 COURT REPORTER: Can you speak up or into  
20 the microphone? I'm having a hard time  
21 understanding you.

22 MR. DELAGI: I'm sorry. Is that better? Okay.  
23 I'll start again.

24 There was no new information to report on the

1 State of New York's quest to become NEMSES  
2 compliant. The State of New York, despite a federal  
3 report to the contrary, has not signed on to be  
4 NEMSES compliant yet, but that is a work in  
5 progress and the state is working diligently towards  
6 NEMSES compliance.

7 We learned that the final edits are being done  
8 to the 2006 PCR data with the School of Public  
9 Health, with regard to cleaning up the data set and  
10 providing some analysis and reports, and we expect  
11 that to be distributed shortly.

12 The draft of the request for information for  
13 migration towards an electronic data collection  
14 format has been completed and it is going through  
15 an interdepartmental review prior to its release. We  
16 are concerned that the RFI may not be issued along  
17 with the RFP. That would ultimately lead to a  
18 program due to some significant budgetary  
19 constraints which you've heard about already today.

20 We reported last time, and Miss Geiger spoke  
21 with us again yesterday about the bureau's grant  
22 application with the Governor's Traffic Safety  
23 Board, and we learned yesterday that the funds, if  
24 awarded, would be used for a consultant to work

1 with the State to achieve NEMSES compliance, to  
2 assist in regional pilot applications toward NEMSES  
3 compliance, to assist regions with establishing  
4 electronic formats and to create a format for the  
5 State of New York to accept electronic data from a  
6 variety of different sources. It was made very, very  
7 clear, and we want to make sure it's clear today,  
8 that at no time would grant funds be used to provide  
9 hardware to regions or ambulance services for an  
10 electronic reporting process.

11 The bureau is collaborating with the STAC to  
12 issue a revised trauma report that will be gleaned  
13 from the 2003-2006 trauma registry data and we  
14 look forward to seeing that report.

15 And likewise, working with the School of Public  
16 Health and the EMS-C program to draft a revised  
17 pediatric care document which would depict access  
18 to pediatric care across the state. We expect that  
19 report to come out early next year.

20 We had several telephone calls, e-mails and  
21 meetings with representatives of New York ACEP  
22 and our committee over the summer and we report  
23 progress with the national report card and with the  
24 snapshot of the EMS data points that we discussed

1 here at our last meeting. We expect the national  
2 report card to come out in December, and we are  
3 pleased to report that ACEP did respond favorably  
4 to our concerns about absent or incomplete or  
5 unavailable data elements and its reflection on New  
6 York State EMS. So we hope that that report will at  
7 least be accurate to the degree that it can be and  
8 not give a false impression of some of the things  
9 that occur here or, in the case, do not occur.

10 And we expect to release the findings of the  
11 New York State snapshot in 2009, during National  
12 EMS Week, and you'll recall, from our previous  
13 discussion, that was where we identified a series of  
14 key data points to just kind of get a sense of where  
15 we are in the State of New York with regard to  
16 several key elements.

17 Going forward, we'll continue to work on  
18 developing a series of data points to identify what  
19 EMS agencies and regions want from hospitals in  
20 the form of quality improvement data, and we're  
21 going to use that as a platform to facilitate our  
22 desire to meet with the hospital preparedness folks  
23 so we can have a dialogue with those folks, so that  
24 we can identify just what hospital responsibilities

1 are as it relates to the sharing of protected health  
2 information. And we'll be working with the bureau  
3 on that between now and December.

4 Also, we have a new work item on the table  
5 that will be completed in very short order. You'll  
6 recall that we had talked some time ago that we  
7 wanted to evaluate the effectiveness of our QI  
8 manual and the roll-outs that occurred during 2007.  
9 And in consultation with the department and with  
10 Don Faeth and the peer group, we've agreed that  
11 we're going to distribute a survey to EMS providers  
12 during the Vital Signs Conference, through the  
13 SEMSCO booth, where we will use that survey,  
14 which will be designed to gauge providers'  
15 understanding of and involvement with the QI  
16 process at the local level and to kind of take a look  
17 at the effects of our roll-out and a manual  
18 distribution. Obviously, that will be an anonymous  
19 survey. We're just looking to collect information  
20 from the grassroots level. We feel very strongly that  
21 if we ask agency leadership what their QI plans look  
22 like and QI programs look like, they'll all have  
23 stellar programs. We want to hear from the  
24 providers to make sure that we are getting that

1 information down to the grassroots provider and,  
2 more importantly, that they are kept abreast of the  
3 things that go on in their process.

4 And we actually have one last work item that  
5 we will have ready for you in December. We  
6 received, just about two weeks ago, the final  
7 products that were submitted by each respective  
8 program agency as it related to their respective  
9 region's targeted QI study. We looked at those very,  
10 very briefly yesterday. I commend everybody on  
11 very, very well-done QI projects and very, very  
12 well-organized documents that document that  
13 they're actual annual studies, and we will provide to  
14 you at the December meeting, a very brief table  
15 which will show each region's objective and their  
16 conclusions. We hope to share that information  
17 with everybody, just to foster some dialogue and  
18 give everybody ideas as to what's going on around  
19 the State and perhaps give you ideas of things that  
20 you'd like to look at in your own respective regions.

21 And that is the report.

22 DR. FUNK: Any questions? It occurs to me that  
23 I listened -- as I listened to all these lists of things  
24 coming from the small groups, how much work gets

1 done at these small groups. So I just want to take a  
2 moment just to thank everybody for all the work  
3 they've put in. It's an incredible amount of work,  
4 making this meeting go longer and longer to hear  
5 about it, but it's an incredible amount of work that  
6 gets done. So thank you to everybody that does --  
7 that works on all the small groups and the TAGS.

8 Next up, we have EMS systems. Mr. LaMarca.

9 MR. LAMARCA: Thank you. The systems  
10 committee met yesterday afternoon. The secretary  
11 does have the attendance, and we have no  
12 seconded motions to bring forward.

13 We did have a report from a number of TAGs in  
14 existence, the first being the communication TAG,  
15 which has reported that the survey that they had  
16 performed prior to the May meeting, which was still  
17 left open, had received no new submissions. It is  
18 about thirty to forty percent of the respondents,  
19 which was the EMS coordinators. They have  
20 decided that they will probably have to go directly  
21 to the 9-1-1 communication centers for a little bit  
22 better response to their survey, looking at the  
23 capabilities of the candidates and the manner of  
24 communications.

1           They have decided to put out a position  
2 statement to the 9-1-1 centers for their role or their  
3 involvement in quality improvement process, as far  
4 as the reporting of any of the problems and the use  
5 of -- proper use of the communication system.  
6 We're also going to include in there, in that position  
7 statement, another section on dealing with  
8 inter-operability at the scene of an emergency  
9 between the different services and the need to  
10 address that.

11           They also brought forward to our attention that  
12 the statewide wireless network has issued a notice  
13 of deficiency to their vendor citing multiple  
14 deficiencies in the design or implementation of the  
15 system. That vendor has forty-five days to respond.  
16 It is uncertain as to whether or not the corrections  
17 can be made or will be made or what the future will  
18 hold for it. We did want to put services on notice to  
19 just be aware that there had been an issue raised  
20 and that they should pay close attention to it,  
21 particularly if they put off any radio hardware  
22 changes based upon, you know, the implementation  
23 of systems. So they want to pay close attention to  
24 that.

1           We had -- the safety TAG did report -- I won't  
2 take any time with that, since I did the safety TAG  
3 report separately.

4           EMS code review TAG has not had much  
5 activity during the summer. They are going to get  
6 back with it this fall, looking at certain areas of the  
7 code, particularly looking at ambulance equipment  
8 and looking to stay ahead of the curve here with --  
9 although we heard about the increased cost of fuel  
10 consumption, there's a lot of attention paid to  
11 looking at the vehicles being used today and if  
12 there's ways to improve that efficiency. So we are  
13 anticipating that along with, you know, changes  
14 that might come forward on different types of  
15 vehicles, might also come some space requirement  
16 changes, so we're going to try to look towards the  
17 future with that.

18           We did have a requirement from the state -- and  
19 I won't repeat these because Mr. Wronski has  
20 covered the City of Utica appeal. Also, the  
21 grandfathering issue. We will review the service --  
22 excuse me -- for the record that one service has  
23 surrendered its operating certificate. That's the  
24 Elliott Creek Volunteer Fire Company. It's an

1 ambulance service. And we have two municipal  
2 CON declarations. These are the Town of Stark in  
3 Herkimer County and the Village of New Square in  
4 Rockland County.

5 You've also heard mentioned about the Section  
6 63.8 of the Title 10, which is looking at, you know,  
7 safeguarding the HIV access data, you know, in the  
8 shortfall, the Ryan White. You've heard about  
9 MOLST. There were two other policy statements,  
10 which, again, safety may report. 08-04, which is  
11 passenger restraint devices policy statement, and  
12 08-06, the federal workers disability act, and both of  
13 those are safety-related policies which have been  
14 distributed.

15 We also heard report from EMS for Children that  
16 the results of their survey stands at about -- I think  
17 it's 79.9 percent response. They need about 80  
18 percent, you know, to meet the federal requirement.  
19 So one service out there, if you could please  
20 respond? I think it will put us over the required  
21 amount.

22 And again, interesting data that they will  
23 distribute to us, but there is concerns, also, with  
24 policy and procedures, not just on ambulances, but

1 also in the emergency rooms, and how lack of  
2 having pediatric policies have led to some delays in  
3 actually transferring children to more appropriate  
4 facilities and, obviously, negative outcomes  
5 because of that.

6 I believe that covers the bulk of our report.

7 MR. WRONSKI: I'd like to invite someone from  
8 systems, depending on whether or not you're ready  
9 to attend the EMS coordinators' -- county  
10 coordinators' meeting at the Vital Signs. We're  
11 already -- our peer chair is already going to that. It  
12 might be useful for your communications issues to  
13 come to that meeting. We typically have, I would  
14 say, thirty or more county coordinators at that  
15 meeting. So depending on -- I think it would be  
16 worth, if you're there or someone you want to  
17 delegate, to talk about communications issues to a  
18 larger group. It might be an interesting  
19 conversation.

20 MR. LAMARCA: Certainly we will. I will be in  
21 attendance and I'll see if we have somebody to  
22 speak to the issue.

23 DR. FUNK: Any questions? Mr. Lewis with  
24 legislative, please.

1 MR. LEWIS: Thank you, Madam Chair. Our  
2 meeting was held yesterday at four o'clock.

3 Just two things. We have one seconded motion  
4 to come before the group, a piece of legislation,  
5 that's A-11461. That -- in summary, this Bill relates  
6 to HIV testing, consent for such testing, required  
7 offer for such testing, confidentiality of HIV-related  
8 information and disclosure of confidential  
9 HIV-related information. This Bill did have a lot of  
10 momentum for passage, but a Bill that came to the  
11 floor was a little bit different, so this Bill did not  
12 reach passage stage. With that said, I'd like to see  
13 this group support the seconded motion this year  
14 and again next year, so that we can share the  
15 importance of this Bill being passed in 2009 during  
16 the legislative session. If anybody has any  
17 questions regarding that Bill, I would respond to  
18 them. I would say that HANYS supported this Bill  
19 vigorously and anticipated it would pass, and I  
20 believe it will pass next year.

21 But with that said, I'd like to ask for a vote of  
22 confidence in this A-11461 at this meeting.

23 DR. FUNK: Any questions?

24 MR. DELAGI: Just a quick one. Mr. Lewis, is

1 this the Bill that eliminates the need for source  
2 patient consent in the face of an exposure to an  
3 emergency worker or health care worker?

4 MR. LEWIS: This is the Bill that Dr. Daily  
5 worked on, yes. So I believe so, yes.

6 MR. DELAGI: Thank you.

7 DR. FUNK: Any other questions? All those in  
8 favor of supporting this Bill?

9 SPEAKERS: Ayes. Ayes. Ayes.

10 DR. FUNK: Any against? Any abstaining? We  
11 support this Bill. Thank you.

12 MR. LEWIS: Thank you. Coming before us next  
13 month, which was tabled this month, is F-8184, the  
14 pandemic flu legislation, so I'd ask that those of you  
15 that can download that, take a look at it. I believe  
16 we should support it, but our committee chose to  
17 look at it more closely and support it in December.

18 Also, Dr. Cooper mentioned to me that 97Q  
19 legislation is coming back again, the trauma  
20 program Bill, later this year. I would guess we'll see  
21 it in December or in 2009.

22 The other thing of interest, I think, as we think  
23 about recruitment and retention of volunteer  
24 providers, Mr. Quinn, from FASNY, talked about

1 S-4617A and A-7699A, which passed, that allows  
2 volunteer ambulance and fire service providers, I  
3 believe, to have access to their hometown  
4 municipal insurance, health insurance.

5 Obviously, that's, from what I understand from  
6 Mr. Mastrianni, is that's the local option to make  
7 that access available to those providers. I see it as  
8 an opportunity for some corps to be able to retain  
9 and recruit volunteer providers, and we know  
10 they're sorely needed, so I just think that's worthy  
11 of mentioning. I don't know, Mr. Quinn, if you want  
12 to make any more comments about that. Okay.

13 I think it needs to be known by all of our  
14 providers out there that this is available, and I  
15 encourage municipalities to take a real close look  
16 at that.

17 End of my report.

18 DR. FUNK: Thank you.

19 MR. LEWIS: Thank you.

20 DR. FUNK: Any questions? Mr. Darby's not  
21 here for the safety report. Mr. Bishop, would you  
22 care to do that?

23 MR. BISHOP: Certainly.

24 DR. FUNK: Thank you.

1 MR. BISHOP: The safety TAG met yesterday. I  
2 do want to comment on two policy statements that  
3 were released over the summer. Policy statement  
4 08-04 on safety restraints, passenger safety  
5 restraints in vehicles. This is a policy statement  
6 that is not too dissimilar from the one that had been  
7 on the books for twenty-some years, and one of the  
8 keys to this policy statement is bringing it to life.

9 We noted in the survey about a year ago that  
10 about ninety percent of our providers do not  
11 routinely wear their seatbelts in the back of an  
12 ambulance, and the way to improve this is not with  
13 regulation and policy, although it is helpful. It is  
14 with modeling the behavior. People that are already  
15 doing this job need to demonstrate it to their peers,  
16 to the new providers that are coming into this  
17 system and the experienced providers. Agencies  
18 need to work to enforce it in a positive manner, to  
19 encourage this and to get people to take ownership  
20 of the safety message. They need to believe that  
21 this is going to help them have a longer career and  
22 to go home at the end of their shift. Right now, our  
23 EMS providers tend to believe they're invincible  
24 because they're in a large vehicle, and that's not the

1 case.

2 Policy statement 08-06 on high visibility apparel  
3 is important because it goes into effect November  
4 24th of this year. Everyone who is working on a  
5 right-of-way of a federally funded highway needs to  
6 be wearing MZ Class II or III apparel. The policy  
7 statement from the bureau provides clear guidance  
8 for agencies to become compliant with this matter.  
9 Perhaps another unfunded mandate. This one will  
10 have clear benefits. These type of vests are shown  
11 to reduce the likelihood of a person being struck on  
12 the side of a road. And they are not that expensive.  
13 You can pick them up for \$15, if you're buying  
14 several at a time.

15 At the Vital Signs Conference, we will be  
16 handing out the report on the behavior and  
17 experiences survey that we -- that we conducted  
18 last year. We'll be passing out the report. The  
19 information will essentially be the same that we  
20 provided to this body in March, and we will be  
21 sharing that with everyone who stops by the booth.

22 Our future actions. The committee will include  
23 improving the incident reporting form. We've been  
24 working very closely with the operations portion of

1 the bureau to make sure this form is consistent and  
2 something that agencies will be able to comply with  
3 easily, yet give us good information about what  
4 happens to our providers in the field.

5 We will be working to develop some agency  
6 best practices that people will be able to take back  
7 home and take a look at what their agencies do and  
8 be able to improve the safety at their home  
9 agencies.

10 We also have begun discussions with the six  
11 core sponsors in New York State that have a TME  
12 website that they're able to control the content on,  
13 and we have begun discussions with them to have a  
14 safety corner on that website, so we'll be able to  
15 share this information in a readily accessible  
16 website for providers.

17 And finally, working with the bureau, there will  
18 be some correspondence going out to core sponsors  
19 on developing best practices for safety at their  
20 educational facility. That is the information that  
21 was shared at the May meeting. We brought those  
22 recommendations up in May, and we'll be working  
23 with the bureau to get those out to core sponsors.

24 Are there any questions.

1 MR. MCEVOY: Can you name that website, just  
2 for the home viewers?

3 MR. BISHOP: The website acronym is  
4 funcmes.com, so F-U-N-C-M-E-S dot com. And that's  
5 sponsored by six program agencies and they're all  
6 listed when you go to that website.

7 DR. FUNK: Any other questions?

8 MR. MCEVOY: I might just make one other  
9 comment. As some of you have probably seen on  
10 the list servers in the last few days, that the fire  
11 service is now very concerned about the ANSI  
12 requirement because it conflicts directly with an  
13 NFPA standard for turnout gear and has the  
14 potential to be harmful to firefighters if they're  
15 fighting a fire that happens to be on a roadway and  
16 wearing a flammable vest. So there's some work in  
17 process now that is going to have some impact on  
18 that, because of the conflicts between that  
19 standard with both the NFPA standard as well as  
20 with the municipal traffic control device standard,  
21 and I -- those changes certainly are not going to be  
22 done by November, but I think it bears some thought  
23 process if you're in a position where you're also  
24 using turnout gear, not to buy the \$80 vest but

1 maybe buy the \$15 ones for now until we see what  
2 happens with that standard. And I think those  
3 changes will probably be around summertime next  
4 year, we'll see some relief from that.

5 There is relief in the standard now for police,  
6 and clearly, it wasn't thought about too clearly the  
7 effects that that might have on wearing turnout  
8 gear.

9 DR. FUNK: Any other questions? Thank you.

10 Sharon, do you have anything from EMS-C?

11 Thank you.

12 MS. CHIUMENTO: EMS-C actually won't be  
13 meeting until after this meeting. However, we did  
14 meet in June after your last meeting, so I just want  
15 to let you know where we're at currently with  
16 EMS-C.

17 Primarily we're working to bring ourselves  
18 up-to-date with all of the regulations related to  
19 membership. We not only have regulations now  
20 from the federal government from the EMS-C folks  
21 related to the types of people related to their fields  
22 that need to be on that committee, but also we are  
23 now also working because we're now a state  
24 committee, as well, to do the diversity membership

1 requirements, as well. So we're looking at those  
2 requirements.

3 Also, because we are a new state committee,  
4 we now have proposed by-laws, which we've not  
5 had in the past. And so that's another item that  
6 we're working on and hopefully, we'll be resolving at  
7 this next meeting.

8 In addition to that, we will be electing officers  
9 for the first time. Up until now, we have not. We've  
10 worked under more general guidelines with the  
11 department kind of leading the meetings. In the  
12 future, we will be having a vice-chair -- a chair and  
13 vice-chair. The chair will have to be a physician.  
14 The vice-chair may be a non-physician. And so we  
15 will be hopefully electing those people at this next  
16 meeting, as well.

17 At this meeting, Dr. Funk will be coming to join  
18 us and, hopefully, we'll be looking at some ways  
19 that we can interact directly on EMS-C and -- and  
20 SEMAC and SEMSCO, particularly maybe on issues  
21 related to pediatric inter-facility transport. That's  
22 one of the things that we -- our surveys are back  
23 and so hopefully we'll be looking at the results of  
24 those at our meeting on the 23rd. And Dr. Funk will

1 be present at that time, so hopefully, her input will  
2 be very valuable to EMS-C, and hopefully, on the  
3 reverse, our input from EMS-C will be valuable  
4 coming back this direction.

5 And then lastly, we also will be looking --  
6 working with STAC on the pediatric trauma data and  
7 looking at the new data in that regard, as well. So  
8 we have lots of little projects that we're working on  
9 and, hopefully, many of them will be in collaboration  
10 with the work that you're doing here, as well.

11 DR. FUNK: Little projects for little people.  
12 Perfect. Thank you for that, and I am looking  
13 forward to attending that meeting on the 23rd. I  
14 look forward to seeing these groups, Trauma  
15 Advisory Committee, EMS-C, and this council work  
16 together. We're all serving the same purpose out  
17 there, and to work together on the issues that -- that  
18 are relevant to each of the groups is important for  
19 us to continue to do. So thank you for inviting me  
20 there.

21 Ms. Geiger, do you have anything from STAC  
22 that you'd like to share?

23 MS. GEIGER: Thank you, Dr. Funk. The State  
24 Trauma Advisory Committee just wants to inform

1 this group that it continues to work on the revisions  
2 -- recommended revisions to part 708, which contain  
3 the trauma designation center regulations. They're  
4 making slow but definitive progress.

5 And at the next STAC meeting, which is this  
6 coming Tuesday, the 16th of September, Dr. Marx,  
7 its chairman, plans to have a full committee  
8 conference with his members on this very topic.

9 DR. FUNK: Any questions there? Last  
10 committee. The end of the last set of meetings. I  
11 did appoint a nominating committee led -- well,  
12 consisting of Deb Fults, Warren Darby and Mike  
13 McEvoy. Do you have a report for us?

14 MR. MCEVOY: We do. We convened over the  
15 summer and contacted some candidates eligible for  
16 SEMSCO office based on the by-laws, and as a  
17 result of our canvassing endeavors, we propose the  
18 following slate of officers for the New York State  
19 Emergency Medical Services Council in 2009.

20 Chairperson, Donald Faeth, representing the  
21 uniformed EMTs and paramedics of the FDNY; First  
22 Vice Chairman, Robert Delagi, representing the  
23 Suffolk County REMSCO; Second Vice Chairperson,  
24 Timothy Czapranski, representing the

1 Monroe-Livingston REMSCO.

2 DR. FUNK: Thank you very much for those  
3 nominations.

4 MR. MCEVOY: Thank you.

5 DR. FUNK: Is there any discussion on that? Is  
6 there any unfinished business that we need to  
7 discuss? Is there any new business that we need to  
8 discuss? Yes, Mr. Quinn.

9 MR. QUINN: Mike Quinn. As usual, I'm being a  
10 pain here and holding you up from your travels and  
11 your lunch. However, looking at some of the recent  
12 activities that we've had, I just want to remind  
13 everybody that SEMAC is a committee of this  
14 council.

15 Therefore, I am making a motion that their  
16 procedures include that for any equipment  
17 requirements, they must include a list of vendors,  
18 suitability for field operations, estimated cost per  
19 unit, estimated cost for the entire system, lead  
20 times, funding availability, and a note that they also  
21 -- that the SEMAC committee must be also aware of  
22 the budget, RFP and bid process that happens  
23 through our agencies, for consideration when  
24 promulgating any regulations that require

1 equipment.

2 MR. REISNER: Second.

3 DR. FUNK: Any further discussion? It seems  
4 that perhaps the best way to handle this, should it  
5 pass, is to ask that the SEMAC coordinate with  
6 systems and perhaps finance on issues like this,  
7 because I'm not sure that the expertise sits at the  
8 table to be able to come up with all of this  
9 information. Yes?

10 MR. CZAPRANSKI: Just as a point of curiosity.  
11 Doesn't SEMAC have statutory authority that  
12 doesn't need to be approved by this -- by this body  
13 related to some of those discussions?

14 MR. WRONSKI: Yes, it does. The SEMAC is a  
15 separate statutory body. It is also tied to this body  
16 and coordinates much of its activities. It's -- certain  
17 statutory requirements, such as protocols, need to  
18 be approved by the -- by the council. Other items do  
19 not, such as advisories.

20 The question would be -- and I understand Mr.  
21 Quinn's motion. I happen to agree with the council  
22 Chair that the better way to do this would be that  
23 when there is a significant impact on the system, or  
24 what's being asked, that we do include a

1 requirement that a review be done by the  
2 appropriate sections of the state council, as we're  
3 developing these things and coming to conclusions,  
4 to evaluate what's the impact on the system. This  
5 doesn't mean necessarily that the SEMAC medical  
6 decision will change, but it can certainly provide  
7 guidance for what type of time frame do we need to  
8 implement it. So I think the motion, you know, is --  
9 is fair. How you accomplish that, I tend to agree  
10 with the Chair that that needs to be a marriage  
11 between the SEMAC and other committees here.

12 DR. FUNK: Other discussion? Yes.

13 MR. FAETH: Where I can appreciate the intent  
14 of the motion, I have a bad feeling that this would  
15 basically strap the SEMAC to the point where they  
16 would never move on pushing forward on what's  
17 best for the patient in new equipment and practices.  
18 You know. I hate to use the word "unreasonable,"  
19 but I think that they have an enormous workload to  
20 begin with. For them to be able to do all that type  
21 of research on each piece of equipment from all the  
22 different vendors, I don't see that as being feasible,  
23 personally. It's just my personal opinion, but, you  
24 know, I know that there is -- this is an area we need

1 to look at and we need to, you know, assist,  
2 especially the commercial providers with, because  
3 we don't want any harm to fall upon them. But we  
4 also need to get the work of the council done, and  
5 that's going to be problematic as far as I'm  
6 concerned.

7 MR. QUINN: Don, I accept your concerns.  
8 Okay? And we're not trying to hold up people  
9 making legitimate medical decisions. However, I  
10 think we need to get a little bit of reality included in  
11 some of these requirements and requests. Okay? I  
12 think, some days, reality isn't there. Okay?

13 And it's not just -- it's just not -- not just our  
14 friends in the commercial services that have a  
15 problem with the finances of implementing some of  
16 these things. Our fire districts, for instance, have a  
17 budget process that goes through. Every year, they  
18 have to put out a new budget. When they go to buy  
19 equipment, they have to go out for bids and get bids  
20 back through and go through that acceptance  
21 process. And if you've read the articles in the last  
22 couple of years and some of the law changes,  
23 budget -- the Division of Finance and Control in the  
24 state does a lot of audits there. Okay? So you've

1 got to be very careful how that gets handled.

2 MR. WRONSKI: If I can bring up -- you know,  
3 one of the things the body does not want to do --  
4 and I would follow Mr. Faeth's discussion on this.  
5 You don't build requirements for the medical body  
6 that makes it impossible to do its job, and in fact,  
7 the department would oppose that. But you do  
8 build. And whether that's a reality check for  
9 medicine or whether it's a -- simply the proper way  
10 to do business, is that the marriage between the  
11 two groups should occur.

12 I actually questioned just how much even the  
13 council is responsible to look in detail at all of the  
14 costs of the system. I think they have to consider  
15 it. I think they have to have a sense of what the  
16 impact is. I don't think they need to know all the  
17 details, I think, at the regional and local level.  
18 That's why we have region representatives here and  
19 association representatives to come to the table  
20 and tell us. Listen -- and we heard it before, very  
21 loud and clear at this table, so I don't think the  
22 process doesn't work. I think we just have to apply  
23 it more rigorously.

24 Miss Geiger reminded me that during the

1 12-lead discussions, there was a definite process  
2 that was put in place to look at the impact of  
3 12-lead. And there was surveys done and reviews  
4 done by the committees. And this, in my view,  
5 should not happen for every piece of equipment, but  
6 it should happen when there are very serious  
7 concerns brought out with, Can we do this in the  
8 next year or six months or whatever?

9 So I would just ask the council that if they  
10 make a motion, they modify it to say that  
11 operational considerations, which might include all  
12 the things that -- that have been put on the table in  
13 this motion by Mr. Quinn, be considered by -- by the  
14 council in their review and that they work with  
15 SEMAC as it moves ahead with these medical  
16 recommendations.

17 But I do not think it's appropriate and workable  
18 to say to a group of 21 physicians that, You guys do  
19 the operation piece. That's really not how we've  
20 operated in the past. That would be something  
21 different. But consider the operation piece as  
22 certainly a reasonable request.

23 MR. ZEEK: I would make that motion.

24 DR. FUNK: Are you requesting to amend the

1 motion that's on the floor?

2 MR. ZEEK: No. I'm going to make a new motion  
3 and --

4 DR. FUNK: We have to vote on the motion  
5 that's on the floor. There's a seconded motion to  
6 include a lot of details about the --

7 MR. QUINN: I would accept a friendly  
8 amendment to reflect --

9 MR. ZEEK: I'll make an amendment that the  
10 standards developed by medical standards and the  
11 SEMAC, where appropriate, be reviewed for  
12 operational impacts by the appropriate state  
13 council committee.

14 MR. QUINN: That's okay.

15 DR. FUNK: That's accepted?

16 MR. QUINN: All right.

17 DR. FUNK: Is there a second to accept that  
18 amendment?

19 SPEAKER: Seconded.

20 DR. FUNK: Is there any discussion on this  
21 amendment -- on this motion now? All those in  
22 favor?

23 SPEAKERS: Ayes. Ayes. Ayes.

24 DR. FUNK: Against? Any abstaining? Thank

1 you. That certainly will -- I think will not necessarily  
2 change the discussion, but it will put more format to  
3 it. We do, certainly, at the medical standards and  
4 SEMAC, discuss operational issues, but perhaps  
5 now, we can discuss them with more detail and  
6 input from other committees.

7 MR. QUINN: Thank you.

8 DR. FUNK: Thank you. Any other new  
9 business? Is that all you have? Do I hear a motion  
10 to adjourn today? Second?

11 MR. LAMARCA: Second.

12 DR. FUNK: All in favor?

13 SPEAKERS: Ayes. Ayes. Ayes.

14 DR. FUNK: Okay. Drive safe. Be good.

15 Thank you.

16 (Whereupon, the meeting adjourned at 11:54  
17 a.m.)

