NEW YORK STATE

EMERGENCY MEDICAL SERVICES COUNCIL

(SEMSCO)

December 3, 2008
9:10 a.m. - 12:07 p.m.
Best Western Sovereign Hotel
1228 Western Avenue

Albany, New York

APPEARANCES:
Ed Wronski
Michael Dailey, MD
Mark Henry, MD
Marjorie Geiger
Michael Mastrianni
Donald Faeth
Edgar Wedge
Michael T. Quinn
Andrew LaMarca
Jim Stairs
Donald DuVall
Paul Cousins
Storm Treanor
John Hassett
Steve Kroll
Vincent Faraone
Deborah Funk, MD

Bradley Kaufman, MD
Robert Delagi
Debra Fults
Alan Lewis
Walt Reisner
Warren Darby
Colleen Vesely
Marvin Raidman, M.D.
Mark Zeek
Dan Blum
Arthur Cooper, M.D.
Tim Czapranski
Michael McEvoy

Michael Washington

APPEARANCES: (Continued)
Anthony Billittier, M.D.
James O'Connor

1 DR. FUNK: I understand
2 that we're still working on the
3 details of the webcast. We are
4 being recorded. It may not be live,
5 so still pay attention to what
6 you're saying, doing, and keep in
7 mind that breakfast is right behind
8 me, so we'll be counting those
9 muffins on the internet.
10 So, welcome to the last
11 meeting of the State Council for
12 this year. It is my pleasure to ask
13 the secretary to please take the
14 roll.
15 (Roll call vote was taken.)
16 DR. FUNK: Thank you. I'm
17 going to ask for approval of the
18 September 11 minutes, if anybody has
19 any comments, corrections, or any
20 motions for approval?
21 MR. LEWIS: Motion to
22 approve.
23 DR. FUNK: Any second?
24 SPEAKER: Second.

1 DR. FUNK: All those in
2 favor? Any opposed? Abstentions?
3 We approve the minutes.
4 Now, what I would like to do
5 is first remind everybody to stay
6 off the internet on your own
7 personal computers because we are
8 having difficulties with the server
9 today, so if you intend for your
10 colleagues at home to see this
11 presentation, stay off the internet,
12 please. Thank you.
13 I do want to now go off the
14 record but stay on the webcast for a
15 presentation. I'm going to ask
16 Marjorie to introduce the
17 presenters, please.
18 (Discussion was held off
19 the record.)
20 DR. FUNK: Back on the
21 record and continue with the
22 meeting. Thank you very much to
23 both Martha and Diana. When I
24 attended the EMSC meeting, I was

1 really amazed by, number one, the 85
2 percent response rate, so I am going
3 to ask if you do any survey I -- but
4 the data, while it is encouraging,
5 it shows that we do have a lot of
6 work to do, and then there is more
7 than just looking at obviously the
8 inter-hospital agreements with
9 hospitals. We have to talk about
10 how EMS is involved in that, and I
11 am sure that that is coming up very
12 soon on your agenda and ours. So,
13 thank you very much for both of you,
14 and good luck to Diana getting home
15 tomorrow.
16 DR. COOPER: On behalf of
17 the EMSC subcommittee, I -- we all
18 owe Martha a tremendous debt of
19 gratitude for putting this survey
20 together. As you gathered from her
21 presentation, the survey itself was
22 difficult enough but follow-up was
23 even more difficult.
24 I think the -- there are a

1 couple of points of good news, as
2 she mentioned. First, we are far
3 ahead of many other states in the
4 nation. The bad news is, we're
5 nowhere near where we need to be.
6 However, I think there is -- if not
7 a silver lining, at least a pewter
8 one, to this particular cloud.
9 Studies done by one of our
10 colleagues on the EMSC subcommittee,
11 Dr. Robert Candor, the Director of
12 Pediatric Critical Care and Medicine
13 at Upstate Medical University in
14 Syracuse, has shown, based on
15 analysis of statewide SPARCS data,
16 that most critically injured kids
17 and ill kids do end up in pediatric
18 tertiary care centers for their
19 care. The problem is that we have
20 not formalized the system to ensure
21 that that happens. And I think
22 Martha's point that, particularly
23 with respect to disaster of surge
24 circumstances, those have to be

1 formalized, couldn't be closer to
2 the truth.
3 The EMSC subcommittee is
4 meeting tomorrow, and I'll be sure
5 to tell them the great work that
6 Martha presented here and your very
7 kind reaction to it. Thanks, Deb.
8 DR. FUNK: Thank you. The
9 correspondence that I've had will
10 come up certainly in other parts of
11 other people's reports, and I'm
12 going to save my comments for the
13 end. Any reports from the first or
14 second vice chair?
15 MR. FAETH: I have
16 actually one comment. I just wanted
17 to acknowledge the extraordinarily
18 hard work and dedication of the DOH
19 staff with regards to the Vital
20 Signs Conference. With budget cuts
21 that we have, diminished resources,
22 and the fact that they had to put
23 this event together with 30 percent
24 less staff personnel, I think they

1 did a fantastic job and the
2 conference went off very well. End
3 of my report.
4 MR. DELAGI: No formal
5 report, but just to echo Mr. Faeth's
6 comments, and let you know that it
7 was my pleasure to serve and
8 represent you all from the -- that
9 night and a job well done.
10 DR. FUNK: Thank you both
11 for representing me. I'm sorry that
12 I wasn't able to attend.
13 Mr. Wronski.
14 MR. WRONSKI: Thank you.
15 I appreciate the comments about the
16 staff and Vital Signs. It is an
17 event every year that we actually
18 enjoy doing; although, it's a lot of
19 work. If anything, I appreciated
20 staff this year because we did have
21 to leave behind quite a few staff
22 for travel cost reasons. We were
23 asked to cut back, and it was
24 approximately a third of the staff

1 that we still managed to pull the
2 conference off, but a lot of that
3 also has to do with the people who
4 attend. You know, if you don't come
5 to the conference, it's not
6 successful. So, you know, we still
7 had a successful conference, and
8 people came in from across the
9 State, and we're happy they enjoyed
10 it.
11 In the State report, the first
12 item is always the one that's most
13 difficult, and that's the budget.
14 The budget is not improving. I
15 don't have the details any more than
16 you do, but my understanding is that
17 the Governor's budget will be out
18 sometime in mid-December, probably
19 within the next week or so. So, I
20 would take a, you know, close look
21 at that.
22 In regard to EMS, I have no
23 indications that anyone plans to cut
24 EMS, but at the same time we're not

1 looking at getting any additional
2 funding. What does occur over
3 time -- and I think I've mentioned
4 this before to the Council -- is
5 that each year the rollover that
6 we've had is getting less and less,
7 so that while we will not have
8 expended all of our dollars this
9 year, which means that we get to use
10 them next fiscal year, there are
11 much less. There have been years
12 where we've had three and a half to
13 four million left over from the EMS
14 budget. That was many years ago.
15 We're now down to, I believe this
16 year we'll be somewhere in the area
17 of two million dollars left over,
18 maybe two and a half, but it could
19 even be under two by the time the
20 final count is taken. What that
21 says to me is that with ordinary
22 growth and costs, probably by fiscal
23 year -- the end of fiscal year
24 '09,'10, we may have little to no

1 rollover funds. The fund -- again,
2 the fund will pay business costs but
3 you won't have the rollover, and
4 that's critical because the rollover
5 gets used. So we will have to put
6 on the table in the future what to
7 do, how to reorganize what we do,
8 maybe reallocate funds, shift them.
9 I think Finance might have some
10 recommendations regarding training,
11 either at this meeting or the next
12 one, and how to fund that, but we
13 have to take some hard looks. I do
14 not expect additional funds to be
15 available in the State budget for
16 the next at least two fiscal years,
17 and so we have to be frugal and look
18 at what we do. From the State
19 perspective, we're doing that.
20 We're limiting our travel, we are
21 going to be examining how to conduct
22 additional meetings more by
23 electronic means than actual
24 face-to-face meetings. While that

1 doesn't mean the State Council will
2 do that in its primary meetings, the
3 four meetings we hold a year, that
4 may, in fact, happen in a couple of
5 future meetings in the next fiscal
6 year, depending where the budget
7 goes and how the economy looks over
8 the next 12 months, but we will have
9 meetings one way or the other,
10 hopefully.
11 Let me move on. There was a
12 major issue that came up in the
13 Education Committee yesterday which
14 was covered, and we've alluded to it
15 before, is the State exam. As of
16 this morning, I do not have word
17 that an extension of the current
18 exam contract has been approved yet.
19 We do expect approval. It doesn't
20 make sense not to approve the
21 extension, but we do not have that
22 approval yet. We do have it within
23 the Department. We're waiting for
24 the Office of the State Comptroller

1 to give us the green light and
2 extend the existing contract. As
3 many of you know, there is an RFP
4 which closes out, I believe,
5 December 5, and we'll be awarding a
6 new exam contract to another
7 contractor but there won't be time
8 to put that in place for the January
9 exam, and we've asked for a
10 three-month extension for the
11 current contract. So we'll let you
12 know as soon as we know, if we get
13 that extension or not. If we do
14 not, we have plans in place to
15 extend certifications of individuals
16 who are recertifying, but new EMTs
17 will have to wait until the exam
18 process is ready if it is cancelled
19 in January.
20 There has been some -- since
21 the last time, there was some
22 question raised on MOLST. One of
23 the things -- as all of you know,
24 MOLST is the Medical Orders for Life

1 Sustaining Treatment that the
2 Department supported and which
3 legislation supported in the pilot
4 first, and now it's on a statewide
5 level. The form may be used and
6 honored by EMS. And when I say used
7 by EMS, EMS doesn't get the form to
8 give to the patient. This is
9 actually something that occurs
10 between the patient and their
11 physician in a decision of
12 end-of-life treatment and the wishes
13 of the patient in those end-of-life
14 moments. But this form, as everyone
15 knows, moves from EMS to the
16 hospice, to nursing homes, to the
17 hospital, and it crosses a lot of
18 bounds. It also allows the current
19 MOLST, and it is usable across the
20 State now, is that there is a DNI
21 section, a Do Not Intubate section,
22 which EMS may honor if they're
23 presented with the MOLST form. But
24 one of the things I want to clarify

1 is that the MOLST is not a
2 Department of Health form. It is a
3 private -- privately produced and
4 delivered form that is accepted by
5 many hospitals, and they're working
6 with Blue Cross Blue Shield Excellus
7 to promote this product. We are --
8 we have finalized the policy to
9 discuss the MOLST form so that EMS
10 providers know what it is and how to
11 utilize it, but we actually do not
12 produce it or print it. So what you
13 need to do is go online and to
14 understand what the form looks like
15 and how to respond to it if health
16 care institutions and patients in
17 your community decide they want to
18 use it. It is a not mandate. The
19 MOLST may not be used in your
20 community, but I do believe that
21 you're going to see a widespread use
22 of MOLST over time because it is a
23 very comprehensive form, but I want
24 to clarify it. It is not a State

1 Department of Health form; although,
2 we will comment on it and have a
3 policy on discussing it for
4 informational purposes. And that
5 policy will be out next week.
6 The issue on capnography was
7 discussed at SEMAC. I'm going to
8 wait until the SEMAC report for that
9 to be discussed, but primarily I
10 just want to make it clear that the
11 capnography SEMAC advisory is with
12 the Commissioner's office now. It
13 had Legal review. There were some
14 modifications. The recommendation
15 that, you know, my office has made
16 to the Commissioner is to support
17 it. We anticipate the Commissioner
18 is going to support the advisory.
19 The only difference is that we have
20 to clarify that the mandate to use
21 the piece of equipment, the wave
22 form capnography, all right, cannot
23 be done by an advisory, but the
24 advisory does, in fact, establish a

1 standard of care, all right? So,
2 that's very powerful in and of
3 itself, but I think there will be
4 further discussion later at the
5 Medical Standards Committee on this.
6 I'm going to have a meeting
7 this afternoon, just to let you
8 know, at the request of the Chair,
9 Dr. Funk, and others, to discuss
10 some of the issues we have in EMS
11 about getting EMS the ability to be
12 trained and clinical skills training
13 done in hospitals and the
14 relationship between hospitals and
15 EMS when EMS, you know, goes into
16 the hospital. We're going to sit
17 down for a little while today and
18 lay out a strategic plan on how to
19 move ahead and approach this issue
20 so that we can try to resolve it, if
21 we can, during calendar year 2009.
22 I have commitment from the Bureau of
23 Hospital Services to participate in
24 this and they're very supportive.

1 They want to make sure that EMS and
2 the hospitals work together
3 cooperatively in the systems. So we
4 are going to have a short meeting
5 today with a few people regarding
6 the subject and report out on it in
7 February. And my anticipation is we
8 will have a meeting with Hospital
9 Services prior to the February
10 meeting and then potentially from
11 there move on to talks with others
12 including various associations who
13 might be interested and my guess is
14 the State Education Department.
15 So I wanted to report also on
16 our trauma system. Again, we did
17 lose an area trauma center, the
18 Arnott Ogden Medical Center, which
19 operates in the Southern Tier area
20 in Elmira. It could not maintain
21 its staffing for general trauma
22 surgery, and this -- this is quite a
23 shock because, you know, the core of
24 any trauma center is their trauma

1 surgeons, and in this particular
2 case this area center could not
3 field enough trauma surgeons,
4 surgeons committed to trauma and
5 experienced in trauma to cover the
6 hospital. And I had had
7 conversations with them previously
8 on some other issues but this one
9 came even as a surprise to me.
10 We've had issues regarding
11 orthopedic surgery and a variety of
12 ancillary surgical specialists in
13 other hospitals who were not
14 available, but I've never seen where
15 the trauma center could not find
16 enough trauma surgeons to cover the
17 facility. But they could not. They
18 are very committed, though, to doing
19 that, and there are efforts underway
20 to identify surgeons who will come
21 in and cover that program. But as
22 of November 1, Arnott Ogden is no
23 longer a trauma center, and so the
24 EMS system in that area is working

1 out its own details on what to do
2 with trauma patients. Most trauma
3 will still go to Arnott Ogden
4 because they have surgical
5 capabilities, although not the
6 trauma surgeons that they had
7 previously. And they have lots of
8 other capabilities, but certain
9 major trauma patients will have to
10 be moved on or directed to one of
11 the regional centers that exist
12 above the Southern Tier but are a
13 longer transport. And in some cases
14 the decisions will be made by the
15 EMS system to cross the border and
16 go into Pennsylvania. And, you
17 know, I've been queried about that.
18 I've indicated that on a
19 patient-to-patient basis you have to
20 make those decisions. They're made
21 every day now for many types of
22 patients. And if it's in the
23 patient's best interest, and you
24 have to leave the State, you leave

1 the State. But, again, EMS -- this
2 is difficult for them. In any
3 event, it requires more of a
4 commitment in the transport of the
5 patients and the identification of
6 the patients and what to do with
7 them, but I will say that in my
8 conversations with the Southern
9 Tier, both the hospitals and the EMS
10 leadership, they've really risen to
11 the occasion and at this point are
12 doing a good job, but we hope that
13 Arnott Ogden is able to come online
14 sooner.
15 The membership issue and where
16 we have some holes currently on
17 members, we are moving ahead on
18 that. We've met with our liaison in
19 the Department of Health. We are
20 presenting a package again to go
21 forward, and we have identified
22 three new members for the Council
23 who will meet the diversity issues.
24 And we hope the new package we put

1 forward will also have an impact on
2 consideration of a final approval of
3 other vetted members. And we do
4 have two members who did -- have
5 waited awhile with the SEMAC.
6 Dr. Goodman from Suffolk County
7 received his letter and has been
8 vetted. And Dr. Davidoff, while he
9 hasn't received his letter, he's
10 gone through the final review
11 process, and my understanding is a
12 letter is forthcoming. So I think
13 what we'll see is more and more
14 movement on the membership issue as
15 we go into 2009. But backing up a
16 little bit, it is the responsibility
17 of all of us to continue to look at
18 ourselves and how our membership is
19 composed, how our community looks,
20 and to reach out and try to find
21 members who represent your
22 community. And if you have a
23 community that has diverse
24 membership, it should be reflected

1 in your seated membership, and it
2 should be reflected in this body.
3 So, this is an ongoing process that
4 we're going to continue over the
5 next few years, and I think it's
6 only right that we do that. Yes.
7 MR. QUINN: Just a quick
8 comment on the membership.
9 According to my looks at the
10 membership as it stands right today,
11 nobody in this room, sitting at this
12 table, has an active membership.
13 Okay? Nobody -- nobody has been
14 reappointed who should be
15 reappointed.
16 MR. WRONSKI: Thank you,
17 I do realize that. But again, like
18 I said, we're moving ahead. We hope
19 to see some progress in 2009. At
20 the same time, I hope to see
21 progress from you in the regions for
22 potentially new members in the
23 future. So it is a partnership, and
24 I hope we can work on that together.

1 MR. DARBY: Question.
2 MR. WRONSKI: Yup.
3 MR. DARBY: With respect
4 to a couple of SEMSCO meetings ago,
5 we were asking to look at the
6 by-laws and see if there is a way
7 that the alternates or somebody
8 could vote for a region that doesn't
9 have the option to vote -- hasn't
10 had for, in my case, two years. And
11 several other regions are in the
12 same situation where our member,
13 under the by-laws, could continue
14 but they're no longer here. Has
15 there been any work done or any
16 thought?
17 MR. WRONSKI: I've asked
18 the question. In the statutory
19 body, voting privileges are to the
20 vetted members. So right now,
21 participation is there but the
22 actual ability to vote on
23 particularly statutory matters, is
24 the vetted members. But you can

1 certainly participate in
2 subcommittees and vote as though
3 there is -- but at this table for
4 statutory matters, it has to be a
5 member who has been vetted.
6 MR. DARBY: So the way
7 it's set up then, we have no right
8 to vote.
9 MR. WRONSKI: No --
10 MR. DARBY: In our case,
11 it's two years.
12 MR. WRONSKI: In your
13 case, it may be so. There a lot of
14 members at this table, while they
15 haven't been revetted, they're
16 allowed to vote because they're
17 continuing to sit, and they were
18 previously vetted so they can vote.
19 But there are some members who are
20 affected by this. Yes.
21 MR. DELAGI: Sorry. Just
22 a tag onto that question. Part of
23 the discussion that Mr. Darby
24 references included looking into the

1 possibility of whether alternates
2 could be vetted so that they could
3 vote in the absence of the member of
4 that particular region. And we
5 discussed it specifically in the
6 context that if a member does
7 participate -- an alternate, I
8 should say, does participate and is
9 in attendance that it would be
10 preferable that that region maintain
11 its ability to vote on any related
12 matters. So, not to bog down the
13 process of vetting with more people
14 to be vetted but that's part of the
15 issue.
16 MR. WRONSKI: Yeah. My
17 understanding, and it had to do with
18 another council that we had
19 conversations with, our council
20 liaison, was that in the statute, if
21 it has a set number of people who
22 are the council members, those are
23 the only ones that can be vetted.
24 So we are limited, I think,

1 currently to 32, and so that limits
2 it. Yes.
3 DR. COOPER: I don't want
4 to prolong this discussion, but I do
5 think that in our ongoing
6 discussions with the Commissioner's
7 Office on this issue, it might be
8 worthwhile to raise the issue as to
9 which causes the greater harm to the
10 public health, lack of diversity on
11 this council or lack of
12 representation from, you know,
13 geographic areas of the State, such
14 as Mr. Darby's that have not a
15 representative for more than two
16 years. I can't answer that
17 question. I'm not a philosopher but
18 or a medical -- but I do think that
19 there does come a point when the
20 denial of voting rights to a
21 representative of a significant body
22 of the population does become, you
23 know, a matter of some urgency. And
24 I wonder, understanding and deeply

1 respecting the Governor's statements
2 regarding diversity, and
3 particularly coming from the area of
4 the State in which I personally
5 reside where diversity is a huge
6 issue, you know, that's an issue, of
7 course, that has my full and
8 complete support. But I wonder -- I
9 do wonder if there might be some
10 possibility in the vetting process
11 for some kind of provisional
12 approval until such time as a full
13 vetting can occur. I don't know if
14 that question has ever been posed.
15 It might be something that could
16 facilitate some of the discussions
17 here, and I just raise that for your
18 consideration.
19 MR. WRONSKI: I have a
20 meeting, as do all of the liaisons
21 to all councils in the Department of
22 Health, and there are 50 other 60 of
23 them. That's just the Department of
24 Health. All State agencies are

1 having these meetings in January who
2 have councils, and every state
3 agency has at least one council. I
4 have the privilege of working with
5 four councils, and it is a
6 privilege, and Mr. Darby knows that,
7 that it is a privilege to come here.
8 So, I'll be attending this meeting
9 as well as my liaisons to the
10 different councils. It's being
11 orchestrated by the liaisons to --
12 our specific liaison to the
13 Governor's Office, and I believe the
14 agenda is being set by the
15 Governor's Office. It's to discuss
16 councils in general, how to manage
17 them, how to fund the meetings, what
18 the rules will be, and I believe
19 part of the discussions will also,
20 you know, be on membership. What I
21 will do at that meeting is also pose
22 some questions, some generalized
23 questions that I've heard today and
24 at other times at that meeting and

1 see if we come back with some
2 answers that help you. I can tell
3 you I've met a couple of times since
4 the last meeting with our DOH staff
5 who oversee all the councils and the
6 membership issues, and they
7 understand the issues here, they do.
8 And there is -- we believe there
9 will be some movement that you'll
10 see in 2009, particularly as we make
11 more appointments to get
12 representation on the bodies. And
13 we have made efforts and have had
14 some success on that. You'll meet
15 some new members at the February
16 meeting. So -- but I will have this
17 meeting in January, it's mandatory,
18 so I'll bring back information from
19 that meeting to you as well.
20 The last time we talked a
21 little bit about -- and it came out
22 of the capnography discussions --
23 defibrillation and how many
24 ambulances in the State of New York

1 actually have a defibrillator on
2 them when they operate. And we
3 heard that in some cases it wasn't
4 necessarily true in some of the
5 interfacility transports, and it
6 might be somewhat true in the 911
7 system. So we did a survey. It's
8 not a complete survey yet, but we
9 had 29 counties respond, and we also
10 queried the 23 largest providers in
11 the ambulance service in the State
12 and asked them questions. Broadly
13 speaking -- and I discussed this
14 yesterday as well, and I think the
15 Systems Committee may discuss it as
16 well -- the picture is not bad.
17 We're definitely in the 95
18 percentile of coverage. What we do
19 have is a particular outlier, you
20 know, of service who during
21 interfacility transports may not
22 have an AED on all their ambulances,
23 but most do, at least the ones who
24 have reported to us, both emergency

1 and non-emergency calls. So it's
2 our belief that mandating a
3 defibrillator of some nature, okay,
4 on every ambulance is not going to
5 have a giant financial impact for
6 most of the system. Most of the
7 system is there, all right, well
8 into the 90 percentile. One service
9 will have to work on this, but my
10 recommendation is that this council
11 at the February meeting, and we'll
12 come up with some language, vote on
13 an addition to the equipment list
14 for ambulances that will include --
15 it will say every ambulance, when it
16 is responding to either an emergency
17 or non-emergency call in
18 transporting a patient, must have
19 the capability of -- must have a
20 defibrillator, a machine that will
21 defibrillate the heart on the
22 ambulance. We're not going to say
23 if you've got four vehicles sitting
24 in repair or for replacement that

1 they have to have a defibrillator on
2 them, but that if you're going to
3 roll them, you're going to go
4 respond to a patient, move a
5 patient, whether that be emergency
6 or non-emergency, that you have the
7 ability to defibrillate. And so
8 we're going to bring that to the
9 February meeting, and that's the
10 first step for us to take in
11 regulatory process. Know that we
12 have your support to do that and
13 that we're going to move ahead with
14 that so that sometime -- my guess
15 would be, since it's a simple
16 addition to the regulation, is
17 sometime by the end of 2009 we could
18 have that in place and -- but I'm
19 putting that out on the record. You
20 know, if there are people here that
21 are going to tell me this isn't
22 going to happen, speak up, but I
23 would like to give word to everyone
24 now that we're going to be pushing

1 this point and so that by 2010, when
2 ambulance services are inspected,
3 some point in 2010, we will have a
4 regulation in place, not just a
5 protocol and a treatment requirement
6 but that a demand that an AED be on
7 every ambulance that moves in the
8 State of New York.
9 MR. LEWIS: Comment?
10 MR. WRONSKI: Yup.
11 MR. LEWIS: Thank you,
12 Mr. Wronski, first of all, for doing
13 the survey. It gives us a better
14 feeling, an understanding of what
15 the impact will be on our industry.
16 But also I think the time will allow
17 the service in question, that may
18 not meet that standard, to prepare
19 for it. Clinically, nobody would
20 argue with the decision for AEDs on
21 every ambulance. It's the issue of
22 how do you finance these costs?
23 This also brings to mind the need to
24 mention that going forward, when

1 Medical Standards or SEMAC plans or
2 thinks of new, innovative
3 technologies that will make a
4 difference, the industry will
5 support that, but what we need your
6 understanding and sensitivity to is
7 the cost. The bottom line for
8 ambulance services in the State of
9 New York in particular is there is
10 no margin. And as we see shrinkage
11 in Medicaid reimbursement -- we are
12 already funding Medicaid at 60
13 percent. We're paying for every
14 time an ambulance rolls out of our
15 garage to transport a Medicaid
16 patient. We're subsidizing that by
17 shifting costs. You need to be
18 sensitive to that, and we appreciate
19 the study being done. We believe
20 that preparation can be put in place
21 for this agency to meet this demand.
22 In going forward, I ask for you to
23 think about that when you're at your
24 meetings deliberating about new

1 medications that we pay for that are
2 not reimbursed for or other
3 innovative technologies that will
4 benefit patient care. Thank you.
5 MR. WRONSKI: Thank you.
6 I do hear -- I heard you and others
7 here at the last couple of meetings,
8 and certainly I think we all need to
9 think about that. You know, our
10 hospital system, the Department, in
11 fact, has a CON process so that when
12 a hospital wants to put in place
13 certain state-of-the-art equipment,
14 which might cost a half a million or
15 a million dollars, and there is new
16 and newer equipment coming out for
17 hospitals it seems every other
18 month, the Department requires a
19 need analysis and a cost analysis,
20 et cetera. And so we ourselves
21 should do that here, and it doesn't
22 mean that the equipment isn't needed
23 and it's good for patient care, but
24 we should evaluate the impact on the

1 system always and implement it in a
2 way that the system can tolerate it.
3 Thank you.
4 The last item from my report
5 is a very mixed one on my part, and
6 some of you heard yesterday, but I
7 want to put this on the record at
8 the State EMS Council. My System
9 Director, Marjorie Geiger, who has
10 worked with us, if you don't know,
11 for more than 10 years now -- she
12 reminded me of that fairly recently.
13 I've been with you 10 years, Ed.
14 It's time to break that string, you
15 know. So I'm very happy for her.
16 She has competed for some very big
17 talent, in the Department and
18 outside the Department, for the
19 position of Director of the Patient
20 Safety Center and has won that
21 competition and has been appointed
22 or vetted -- Mr. Darby --
23 MR. DARBY: Marjorie,
24 we've got to talk.

1 MR. WRONSKI: Find out
2 how she did that. But she got word
3 yesterday, literally during the
4 meeting, that the Governor's Office
5 approved her appointment. I would
6 like to congratulate her on that
7 appointment and definitely
8 congratulate her on her commitment
9 to all of you and to me over the
10 last ten years.
11 MS. GEIGER: Thank you
12 very much. As I stated yesterday to
13 your colleagues on the SEMAC, it has
14 been an honor and a privilege to
15 partner with you all of these years.
16 It's actually a decade now. I think
17 that this body has really moved the
18 prehospital and hospital system
19 jointly to a level where patient
20 care has improved. Education and
21 training of our prehospital
22 providers continuously improves, and
23 that's really the operative word in
24 anything that has the bug word

1 "safety" in it, that it's
2 continuous, that it's not stagnant.
3 And so I pay tribute to all of you,
4 and I hope that you continue to move
5 the system forward. Thank you for
6 your time and your energy.
7 MR. WRONSKI: That's it
8 for my report. If there are
9 questions on anything I've covered
10 -- yes.
11 DR. COOPER: Mr. Wronski,
12 the issue of trauma center closures
13 came up yesterday at the SEMAC.
14 This may be something Dr. Henry will
15 discuss under his report but, if
16 not, I just wanted to note on the
17 record that SEMAC did make a
18 decision to formally write to the
19 Commissioner suggesting that trauma
20 is one of those specialties that is
21 underserved in many areas of the
22 State that may not be underserved in
23 other areas and should be considered
24 as a potential recipient for the

1 Doctors Across New York funding that
2 the legislature recently made
3 available. I heard on the radio
4 driving up here this morning that,
5 in fact, the grants had been
6 extended for some months, I gather,
7 because there have not been
8 sufficient submissions as of this
9 date. That, in and of itself, does
10 suggest that there might be a way
11 that trauma might be able to tap
12 into some of that funding and
13 relieve the burden on the citizens
14 who happen to reside in some of
15 those areas that are not currently
16 covered. So I'll defer to the Chair
17 as to how this should be handled,
18 but I would ask that this council
19 join with the SEMAC in writing a
20 letter to the Commissioner on this
21 issue.
22 DR. FUNK: If the Council
23 so desires, we can certainly
24 coordinate a cosigned letter from

1 both the Medical Advisory Committee
2 and the Council? It certainly seems
3 worthwhile.
4 SPEAKER: So moved.
5 MR. LEWIS: Second.
6 DR. FUNK: All those in
7 favor? Any against? I will do
8 that. We will do that. Mike.
9 MR. MCEVOY: Mr. Wronski,
10 could I ask you to read into the
11 record the meetings for 2009?
12 MR. WRONSKI: I forgot to
13 do that. It was one of my agenda
14 items. Okay. Yeah, the meetings
15 will be -- next year will be
16 February 17 and 18, June 9 and 10,
17 September 8 and 9, December 1 and 2.
18 They will also be at the Crown Plaza
19 Hotel in downtown Albany. Everybody
20 get those dates?
21 MR. MCEVOY: Thank you.
22 DR. KAUFMAN: We've been
23 discussing how the medicine of EMS
24 has changed quite a bit, and it's

1 recognized that it's important to be
2 able to do QI on all of these
3 changes, especially so we know that
4 a lot of these changes are safe for
5 the patient. And this has been
6 recognized statutorily in Article
7 30, parts of the 405 regs, even in
8 the HIPPA requirements. However, it
9 seems that many of us are still
10 having problems obtaining outcome
11 data from the hospitals, and without
12 that data it's difficult to do true
13 QI just from our own PCRs. So while
14 it's recognized that we should be
15 able to have this data sharing with
16 hospitals, it's in the current
17 environment difficult or impossible,
18 so I would ask in your meetings
19 later if you could -- if you could
20 discuss that and push for either
21 some joint statement or regulation.
22 MR. WRONSKI: Yeah, I do
23 know, as you know I know, there's
24 many conversations on this revolving

1 around the STEMI system in New York
2 City where there is exchange of data
3 going on but it has been difficult
4 because what does this law really
5 say, what does it allow. And it's
6 not absolutely clear. Even though
7 you can read the language -- it says
8 outcome data -- what does that mean.
9 Okay? There is a real connection
10 and, you know, our DOH council
11 supports that Article 30 says
12 ambulance services may coordinate
13 their QI efforts with hospitals.
14 And so if a hospital is part of your
15 QI system, you know, you can't have
16 data exchange, but a lot of that is
17 a partnership. For instance, if you
18 say to a hospital I'd like the
19 patient chart of so and so, I can
20 tell you what answer you're going to
21 get, and probably you should get
22 that answer. But there are
23 certainly things that would be very
24 useful in the assistance of EMS. If

1 you bring a patient to the hospital
2 and in transport it was your
3 decision to transport them to a
4 cardiac center because you thought
5 something was going on -- although,
6 it would be great to know if your
7 call was right -- and the hospital,
8 in their evaluation with the
9 equipment they have, and the
10 capabilities they have, confirmed
11 for you that, yup, you made the
12 right call here; this was a good
13 move to do. Or, no, and here's why
14 so that you can learn from it, and
15 there are lots of examples of that
16 every day. We would like to see
17 that. What I would ask as a first
18 step, all right, because I am still
19 working with our council on
20 potentially release of a letter that
21 will explain some of this from a
22 pure legal basis, but that's down
23 the road, and I don't know when that
24 would be approved. What can happen

1 in the interim, and should happen --
2 we haven't done it here -- we should
3 sit down, and Mr. Delagi -- I don't
4 think he's here right now. There he
5 is -- and Dr. Kaufman, who chairs
6 the QI Committee, I think it would
7 be important that that committee
8 take a look at, all right, what is
9 it we think we need in general and
10 maybe specifics from hospitals to
11 share? And how would we do that?
12 And make -- and put out a
13 recommendation, all right, that
14 could be used in all regions, you
15 know, when they approach hospitals.
16 Listen, our SEMAC and our state
17 council met, and the law says the
18 following, and this is some guidance
19 and what guidance we are providing
20 to regions as to what would be very
21 useful for them to be able to share
22 with you in the QI process. Maybe
23 kind of identify some of those
24 things, and that would be helpful.

1 And then regarding regulations, we
2 can talk about that after we decide,
3 well, what is it we want? And then
4 how would we write a regulation to
5 support that? Yes.
6 MS. VESLEY: I know in my
7 region I'm able to share a lot of
8 information with my EMS providers.
9 Our hospital lawyer said that we
10 could do it as a QI, an educational
11 component so it doesn't violate any
12 HIPPA regulation. I might suggest
13 that you ask the trauma coordinators
14 what they're currently doing to
15 provide some of that feedback to
16 their EMS people so that you know
17 what's being done in some places and
18 then you can maybe get an idea of
19 how to proceed to get that
20 information more.
21 MR. WRONSKI: Actually,
22 yeah, what I'm hearing there is kind
23 of like best practices, and I have
24 worked with the trauma people, and

1 some of the regions are very
2 successful at doing this, not all
3 are, so it might be useful to share
4 that information across the
5 committees. I still think there is
6 a need to, you know, do what I
7 suggested, but we can build off some
8 of what the successful trauma
9 programs are and then down the road
10 decide, after we've done that, well,
11 what do we still need to do that
12 might require regulation? And I
13 will tell you, I've had ongoing,
14 because of the STEMI discussions,
15 ongoing discussions with Hospital
16 Services who is supportive of
17 whatever we need to do to strengthen
18 that tie and that exchange of
19 information. So, there is real
20 support to do this in both the
21 Department as well as in the
22 industry. We've just got to figure
23 out the details.
24 DR. FUNK: Thank you.

1 Dr. Henry, would you like to give
2 the Bureau report?
3 DR. HENRY: Much of our
4 report will be given during the
5 Medical Standards report, but just
6 let me highlight three other things.
7 One is that Mr. Wronski, with the
8 Bureau of Hospital Services, is
9 going to pursue a meeting addressing
10 education of EMS personnel in the
11 hospital, as well as care rendered
12 during prolonged periods of time
13 when there is a delay in transfer of
14 care to hospitals. So those are two
15 items that we talked about and we
16 were going to pursue.
17 The next of note is that on
18 December 18, there will be a meeting
19 of -- with -- Dr. Morley is calling
20 a meeting about crowding in
21 hospitals, and I'll be attending
22 that meeting in Albany.
23 And with respect to the trauma
24 center closings, I had asked months

1 back that we do this and I think I
2 had asked even further back that the
3 regions identify shortages in terms
4 of specialty care, and that really
5 can only happen in a region where
6 you know among the hospitals where
7 they do or do not have on-call
8 shortages, they may or may not be
9 trauma. And what the significance
10 is to people who live it because the
11 program that Art talked about is
12 not -- it moves people of all
13 specialties, mostly primary care but
14 also obstetricians, surgeons, to
15 areas in need in the State. Again,
16 to be repetitive, one of our
17 products in New York State are
18 doctors. We train a lot of doctors
19 in residences, fellowships. Fifty
20 percent of the ones we train leave
21 New York State, so we export trained
22 physicians. And if there's a need,
23 an unmet need in this State, we have
24 actually an obligation to identify

1 it. Otherwise, the agencies that
2 are trying to move people and locate
3 them, how would they know where to
4 go, except for SPARCS or other
5 databases? So I would ask that
6 people do this. This is something
7 that program agencies can assist
8 REMACs in because the REMACs would
9 have a pretty good feel for
10 shortages of on-call specialists in
11 their areas. I would ask the
12 program agencies to assist the
13 REMACs to come up with shortages
14 across New York. That would be
15 actually a benefit to all of us, and
16 I don't think it would take a lot of
17 work because I bet the REMACs would
18 know, if they sat in a meeting,
19 where there would be real shortages.
20 And the power of the EMS community
21 is, what does it mean to people in
22 terms of travel geography access?
23 And one can describe that. How
24 often does it occur? So, I think

1 that would be very useful to add to
2 a letter to the Commissioner saying,
3 why don't we look at some of these
4 emerging areas as perhaps additions
5 to areas of unmet need in New York?
6 And then we can do something about
7 it, the programs that are already
8 established.
9 I think I want to say that
10 with respect to the presentation of
11 EMS-C on transfers, I don't know if
12 they're aware, but in our
13 regulations in New York, hospitals
14 are required to identify areas,
15 identify types of patients they can
16 treat and have written transfer
17 agreements with other hospitals, and
18 there are six or seven descriptions
19 in the regulations right now --
20 burns, trauma, high-risk OB,
21 neonates. You know, they're already
22 identified. So I'm not sure if
23 someone answered, "I have a burn
24 agreement," whether the survey would

1 say that's adults and children. We
2 don't ask people to separate by age
3 in terms of transfer agreements
4 right now, and -- but if there are
5 things that should be use -- more
6 useful in future requirements of
7 hospitals for transfer agreements,
8 we should have a more detailed
9 conversation because -- have tried
10 to do that already and that is in
11 the regulations. People who are
12 familiar with them, they would see
13 that.
14 The last note I would make, is
15 that I just want to announce that
16 Dr. Craig Van Roekens has taken
17 another professional opportunity in
18 another part of the State. He has
19 resigned his position on SEMAC.
20 He's been a faithful member, and we
21 wish him well, and we'll miss his
22 contributions. Yes.
23 MR. REISNER: Dr. Henry's
24 suggestion along your first point --

1 I sit on the rural health council.
2 We get an annual presentation from
3 the work force development unit
4 area, SUNY Albany. They have the
5 latest information by region where
6 the specialists are in shortage, and
7 rather than reinventing the wheel, I
8 think it might be educational for us
9 to ask somebody to come give us a
10 pitch at one of our upcoming
11 meetings so we can get the latest
12 data. They survey that annually,
13 and it might save a lot of work for
14 everybody.
15 DR. HENRY: That's a
16 useful suggestion and, I think, to
17 have some of that data, Walt. But
18 what I'm thinking about is when you
19 bring a patient to a facility, there
20 are no on-call capabilities for
21 certain specialities, and the
22 movement of such a patient is a long
23 distance, and if that tends to recur
24 among neighboring communities then

1 there is a deficit, at least in
2 terms of emergency care. It may
3 have an identified practitioner in a
4 specialty on a list from the
5 Department of Education working in a
6 particular town but their practice
7 may or may not be full time. It
8 could be limited because of age, or
9 retirement, or what have you,
10 choice. So that's what I think we
11 can add as our community and add
12 what's available twenty-four/seven.
13 MR. WRONSKI: Yeah, just
14 to follow up what Dr. Henry is
15 saying, some of the staff shortages
16 that have affected some area trauma
17 centers were not always because they
18 didn't have a specialist there. In
19 some cases, it was the specialists
20 who work in the community did not
21 want to commit to the on-call, and
22 that happened in Rochester General.
23 And my understanding is that they
24 had nine orthopedic surgeons, none

1 of which would agree to do any
2 on-call for trauma, and the
3 arrangement with a couple of trauma
4 physicians from another facility
5 ended, and those in-house orthopedic
6 surgeons said, well, we're not going
7 to pick it up, and that ended that.
8 And even in the Arnott Ogden
9 situation they have, I think, it's
10 11 general surgeons, but they're not
11 surgeons who feel that either
12 they're capable or willing to commit
13 to the trauma on-call, and so they
14 have to, you know, go out elsewhere
15 and find somebody. So it's a mix.
16 Some places it's -- we don't have a
17 neurosurgeon living here anymore, I
18 can't do it. And in other cases
19 it's we don't have a specialist who
20 wants to commit to on-call, so it's
21 a different situation. And it may
22 be that, you know, REMACs would be
23 able to help identify what are they
24 seeing in their area. You know,

1 what's the specialty issue?
2 Strictly speaking to the on-call,
3 when you need them in the middle of
4 the night do you get it? And if
5 not, what's the specialties we're
6 shortage of?
7 DR. FUNK: It's a very
8 complex question, it sounds like.
9 We can get answers from a lot of
10 different places, but it certainly
11 would be great if there are --
12 available to be able to share that
13 with the areas with an identified
14 need. If there are plenty of
15 physicians around the State, let's
16 figure out how to make it worth
17 their while to spread out and serve
18 everybody. So we can certainly work
19 on that.
20 If we can hear the Medical
21 Standards report, and then we'll
22 take a short break after that.
23 Thank you.
24 DR. MARSHALL: A few

1 things.
2 DR. FUNK: Just a few?
3 DR. MARSHALL: Yeah.
4 DR. FUNK: Why do I not
5 believe you?
6 DR. MARSHALL: Good
7 morning. Medical Standards met
8 yesterday, and we have five action
9 items to bring forward. They need
10 to be voted on, so I'll do them one
11 at a time, the protocols. The first
12 one is from the Western Region.
13 They presented a post-arrest
14 hypothermia protocol. That protocol
15 will permit EMS providers in the
16 region to begin the cooling process
17 in patients who have return of
18 spontaneous circulation after
19 cardiac arrest. Exclusion criteria
20 were discussed at the current time.
21 Trauma patients and pregnant
22 patients are excluded, which is
23 general for these types of protocols
24 at this time; although, there are

1 some studies going on in terms of
2 trauma patients who have return of
3 spontaneous circulation and whether
4 or not they would benefit from
5 hypothermia. Mostly, this will be
6 taking place, I believe, in the
7 Buffalo region. Most of the
8 hospitals are -- four primary
9 hospitals in that region are
10 involved in this and that EMS system
11 is actively working with to help
12 them develop the hypothermia process
13 in the hospital. This is a process
14 that has been in the prehospital
15 setting. It's not that in the
16 prehospital setting patients will be
17 brought down to the temperature they
18 need to be brought down to. I
19 believe the average transport time
20 was 15 minutes is what I recall was
21 mentioned yesterday. So it's just
22 the beginning of the process of
23 hypothermia.
24 In their protocol, basically

1 they will be giving cold saline.
2 They have been given a grant, and
3 they have obtained 15 cooling units
4 to be placed on ambulances to allow
5 for the cooling of the saline that
6 will be delivered at the scene and
7 during transport of these patients.
8 Also, in the protocol is for
9 shivering, which we know increases
10 temperature, Valium. And I have a
11 copy, if anybody did not get to see
12 it but would like to see it or would
13 like to see it again. And that
14 comes forwarded. That was discussed
15 and approved unanimously at both
16 Medical Standards and SEMAC. It
17 comes forward as a seconded motion.
18 DR. FUNK: Are there any
19 questions about this protocol?
20 Awesome. And so it's here as a
21 seconded motion. All those in favor
22 of approving this protocol? Any
23 against? I'm sorry, you're right.
24 Roll call, please. See, I was all

1 ready for it. I was trying to go
2 back.
3 (Roll call vote was taken.)
4 DR. FUNK: Roll call
5 complete. It sounds like that
6 passed. Next.
7 DR. MARSHALL: Next. The
8 second one was -- is New York City
9 Rescue Medic protocol. This was
10 actually approved at a prior
11 meeting, but Medical Standards and
12 SEMAC had some questions about the
13 curriculum; the reason being is that
14 these rescue medics would be
15 operating primarily at, you know,
16 like high altitude rescue and
17 buildings in Manhattan or
18 closed-space rescue and prolonged
19 scene time. Would be doing certain
20 procedures which might include
21 insertion of foley catheter, doing
22 blood tests, testing
23 intra-compartmental pressures, and
24 we had some questions about the

1 curriculum that was going to go
2 along with that because this is
3 above and beyond the New York State
4 Paramedic Curriculum at this time.
5 So that was reviewed by the
6 Education Committee, and with the
7 addition of what to do in the event
8 of a transport infusion pump
9 failure, I believe was the issue,
10 those -- that protocol curriculum
11 was approved. So that comes back
12 now as a seconded motion protocol
13 with the approval of the curriculum.
14 Many of the procedures also that we
15 had questions about that were
16 initially under standing orders were
17 moved to Medical Control options.
18 Remember that during the operation
19 of these protocols, in the majority
20 of instances, there will be a
21 physician on scene because these
22 will be prolonged scene times, these
23 especially closed-space rescue, and
24 collapse, and pending jobs. So that

1 comes forward now as a seconded
2 motion.
3 DR. FUNK: Any additional
4 questions? We certainly thank the
5 Education and Training Committee for
6 going over that in detail. They had
7 a level of expertise to look at this
8 that we didn't necessarily possess
9 at the Med Standards meeting. If
10 there are no other questions or
11 comments, roll call please.
12 (Roll call vote was taken.)
13 DR. FUNK: Thank you.
14 That's approved. The next item.
15 DR. MARSHALL: Okay. The
16 next item is the Susquehanna area
17 protocols. I also have those here
18 if anybody would like to take a look
19 at them again. Basically, with
20 Susquehanna protocols there was a
21 lot of clarification in the EMT-I
22 level skills. There were a lot of
23 clarification of drug dosages,
24 especially in areas like facilitated

1 intubation. You can see that in
2 their protocols that they've made
3 those clarifications in drug
4 dosages.
5 There was also neonatal
6 meconium aspiration. Sharon, help
7 me. Only if it's respiratory
8 distress. That was added. In
9 Susquehanna, they also have
10 inter-facility transports and each
11 of the agencies that do
12 inter-facility transports have their
13 own transport, inter-facility
14 transport protocols from my
15 understanding. But each one of
16 these inter-facility transport
17 protocols are brought to the REMAC
18 for approval. So, that was one of
19 the issues that came up; that's in
20 there.
21 And that was it, and that
22 comes forward as a seconded motion
23 approved by both Medical Standards
24 and SEMAC.

1 DR. FUNK: Any questions
2 about the Susquehanna protocols?
3 Seeing none, roll call vote, please.
4 (Roll call vote was taken.)
5 DR. FUNK: Roll call
6 complete. Thank you. In case we
7 didn't remember that we are all
8 needed around the table, you need to
9 stay awake. Roll call vote -- the
10 meeting. Next.
11 DR. MARSHALL: The next
12 regional protocols were from
13 Westchester. I also have those if
14 anybody would like to see them
15 again. The Westchester protocols
16 were reviewed in-depth and -- as are
17 all the protocols. In terms of
18 Westchester protocols, there was one
19 thing that was removed and that was
20 the administration of intra-nasal
21 Narcan in neonates, and that was in
22 there. That was removed by the
23 region because there was no evidence
24 for its efficacy or use elsewhere.

1 There were some other typos in
2 terms of the American Heart
3 Association guidelines that this
4 body adopted before, and those were
5 all -- will be all corrected, and
6 that comes forwarded as a seconded
7 motion, approved by Medical
8 Standards and SEMAC.
9 DR. FUNK: Any question
10 about the Westchester protocols?
11 Roll call vote, please.
12 (Roll call vote was taken.)
13 DR. FUNK: Thank you.
14 DR. MARSHALL: Getting
15 there.
16 DR. FUNK: I know. Do I
17 look impatient?
18 DR. MARSHALL: The next
19 set of protocols actually -- is
20 actually one protocol. It's from
21 New York City, and this is an --
22 actually -- actually it's an ALS --
23 it's a transport protocol. This has
24 to do with the New York State, New

1 York City Burn Treatment Program.
2 In New York City, in the event of a
3 burn MCI, which we have a lot of
4 patients who are burned who require
5 hospital treatment, we will
6 obviously quickly overrun all of our
7 burn beds in the City as well as
8 other possibly other areas of the
9 State. So in New York City, through
10 this grant, what we've done is that
11 they've taken all the hospitals and
12 divided them into tiers, so we have
13 Tier 1, Tier 2, and Tier 3
14 hospitals. The Tier 1 hospitals are
15 the burn hospitals that currently
16 exist. Tier 2 hospitals are the
17 trauma centers, regional trauma
18 centers in New York City, and Tier 3
19 hospitals are other community
20 hospitals that have agreed to
21 participate in this program. What
22 this program will allow, is will
23 allow transport of patients with
24 burn injures to these other non-burn

1 center hospitals -- either Tier 1,
2 Tier 2 or Tier, 3 -- in the event of
3 a major burn MCI in New York City.
4 It was also -- it will also allow
5 inter-facility transport of burn
6 patients from one hospital to a more
7 appropriate hospital later on after
8 the actual incident has occurred.
9 As part of this program, those
10 hospitals that have agreed to
11 participate, have received equipment
12 and supples to allow them the
13 capability of taking care of ten
14 burn patients for three days. And
15 we had our presentation and went
16 through some of what is available on
17 these burn cards. And that's where
18 we are now. The protocol that was
19 actually changed is a transportation
20 protocol to allow EMS to take burn
21 patients who would normally be
22 transported to a burn center, under
23 our existing protocols, to a Tier 2
24 or a Tier 3 hospital where they

1 would be able to receive the
2 appropriate care so they could be
3 transferred to a more appropriate
4 burn center. And that comes
5 forwarded as a seconded motion. One
6 other thing with that is there will
7 be a -- Dr. Kaufman can help me with
8 this if I get it a wrong, but a
9 virtual burn coordinating center,
10 which will actually be coordinating
11 the transport, inter-facility
12 transport of burn patients
13 throughout the State and maybe in
14 between states, too.
15 DR. FUNK: Any questions?
16 Sounds like fun. Roll call vote,
17 please.
18 (Roll call vote was taken.)
19 DR. FUNK: Roll call
20 complete. Thank you.
21 DR. MARSHALL: I think
22 that's all the action items so --
23 but one thing I would just like to
24 point out is that reviewing

1 protocols is a very laborious
2 process. And the way we have it set
3 up now is, while everybody gets
4 copies of all the protocols, we
5 assign three members of Medical
6 Standards to really review them in
7 depth and go through them. And I
8 thank -- I'd like to thank Sharon
9 Chiumento because she seems to do a
10 most wonderful job for each of them,
11 and she's been an invaluable member
12 of that team.
13 Other information. I was
14 really hoping Mr. Wronski was going
15 to cover capnography, but as you did
16 hear, the advisory is an advisory,
17 and we cannot at this time mandate
18 purchase or use of particular
19 equipment, but I think that you
20 should understand that both the
21 Medical Standards Committee and
22 SEMAC felt most strongly that this
23 is the standard of care in New York
24 State and this is where people need

1 to be moving. There was also some
2 discussion about, at the regional
3 level, if a REMAC put wave form
4 capnography in the protocol and then
5 the protocol was approved by this
6 body, then if you're going to
7 operate within your region, then you
8 need to comply with your regional
9 protocols, but the State could not
10 mandate any purchase of any
11 particular equipment. If I get any
12 of this wrong, Mr. Wronski, please
13 jump right in. So, I think that's
14 all I'll say about that. We also
15 had --
16 DR. FUNK: I believe there
17 is a question.
18 DR. KAUFMAN: I just want
19 to clarify. Well, I guess it's a
20 strange clarification since it's not
21 a requirement. But as far as
22 documentation of the wave form
23 capnography output, there was some
24 discussion about if the SEMAC or the

1 SEMSCO had required any specific
2 documentation requirements as far as
3 downloading the information,
4 printing out the information, or a
5 document on a PCR as we normally
6 would.
7 DR. HENRY: My
8 recollection is that we recommend
9 that the devices be able to have
10 memory, so that you can look back
11 and see what the record showed and
12 that there will be a printout
13 available to give to the hospital.
14 We recognize that some of these
15 printers are specific to the device.
16 You know, they may not be real time.
17 It depends where they're stationed
18 in terms of how you lodge the device
19 and get the printout but that is
20 extremely valuable data to have.
21 And I can tell you from personal
22 experience that to be able to go
23 back and check the memory of what
24 actually happened is invaluable in

1 terms of QI or queries about where a
2 tube was or if it got misplaced when
3 that occurred. So we did recommend
4 that because not to have that may
5 save you a couple hundred dollars
6 and some devices, but it's not worth
7 it.
8 I'd like to say something else
9 about what Lew said before. Some of
10 the regions have adopted this as
11 part of their protocols. We talked
12 about that yesterday at the SEMAC
13 and that's -- that is the practice
14 in their regions, okay. The intent
15 of the advisory is not to mandate
16 that people purchase a piece of
17 equipment, but it does say that, in
18 my mind, that if you don't have the
19 assurance that you can maintain
20 knowledge that the tube is in the
21 right place during transport and
22 transfer of care, that the option is
23 to bag valve mask or use other
24 devices. And that's been -- if you

1 go to the literature in JAMA, that
2 has been proven to be just as
3 efficacious for patients in the
4 pediatric population in Los Angeles,
5 in a very rigorous study. So it's
6 not like you're denying people care,
7 ambulatory care, because in the
8 other arm, you won't have assurance
9 where the tube is. So when you take
10 those unrecognized, mislodged tubes
11 and you factor those in, the bag
12 valve mask was equally efficacious,
13 and that's what the advisory's --
14 the intent is, that says to me in
15 regions that don't have it. I'm not
16 saying you have to buy a wave form
17 capnography for every ambulance. If
18 you take into account the risk
19 benefit of a procedure for patients
20 in this day and age, that is what we
21 would say the standard of care is to
22 assure proper risk benefit.
23 DR. COOPER: I just want
24 to very briefly add to Dr. Henry's

1 remark that there are now two
2 prospective studies in the trauma
3 literature documenting the same
4 findings, as is the case in
5 pediatric patients that have short
6 urban transports, that bag valve
7 mask ventilation is just as
8 effective as endotracheal
9 intubation.
10 DR. FUNK: Mr. LaMarca.
11 MR. LAMARCA: I just have
12 a question. If an agency cannot use
13 wave form, other than switching to a
14 bag valve mask, a lot of the
15 protocols certainly have secondary
16 tube placement -- device is that
17 what role will that play? It's
18 already in a number of the
19 protocols.
20 DR. MARSHALL: Actually,
21 I -- and I can try to address it,
22 but I think part of the advisory is
23 actually a revision of the advisory
24 from 2002 which had those secondary

1 devices in place, has replaced the
2 secondary devices with wave form
3 capnography. And I think that the
4 discussion that has been at Medical
5 Standards and at SEMAC is that if
6 you can't verify tube placement by
7 endotracheal tube, then you probably
8 should use some other method of
9 managing someone's airway. We did
10 have some discussion on whether or
11 not some of these other devices are
12 advanced airway devices, qualify and
13 should have wave form capnography.
14 I don't recall the outcome of that
15 at this moment, but that's something
16 we can look back into. But I don't
17 know for endotracheal tubes was the
18 last thing that I recall. So that
19 wave form -- to answer your
20 question, I think wave form would be
21 the preferred method. And if you
22 can't, then you use some other
23 method, and then the secondary
24 devices might come into play.

1 DR. HENRY: The advisory
2 speaks to intubation, and it talks
3 about wave form capnography as a
4 definitive method to assure proper
5 placement.
6 DR. KAUFMAN: I am a
7 little confused because I would
8 think, from our discussion here,
9 that we would say that those other
10 methods are below the standard of
11 care, and I think that's what the
12 advisory may say. Is that my
13 understanding, that we're saying the
14 standard of care for intubated
15 patients is wave form capnography?
16 DR. HENRY: Right.
17 MR. WRONSKI: Yes, that's
18 correct.
19 DR. HENRY: That's what it
20 says.
21 MR. WRONSKI: That's
22 correct. There's no if's, and's or
23 but's about that. If you intubate a
24 patient, continuous wave form

1 capnography. All right?
2 Documental -- and I'm going address
3 to that. But continuous wave form
4 capnography is -- once the
5 Commissioner signs off on the
6 advisory, and I'll let everybody
7 know that. It hasn't happened yet,
8 but I expect it to happen soon, that
9 that is establishing a standard of
10 care, and services need to
11 understand that. The documentation
12 is critical in any medical
13 procedure, and when the Department
14 takes a look at a case because we've
15 had a complaint, we look for the
16 documentation; did you do the
17 following? And if the standard of
18 care is continuous wave form
19 capnography, and you said you've
20 done it but you have no way to prove
21 it other than that you say you did
22 it, all right, and we've recommended
23 that it be documentable wave form
24 capnography, then frankly, that

1 weighs against you, and the
2 discussion is whether or not you did
3 it or not. And so our advice is to,
4 you know, purchase a capnography
5 device which is capable of
6 documenting the use and results.
7 Yes.
8 DR. KAUFMAN: Well, I'll
9 just tell you our experience a
10 little bit in New York City. So
11 we've now spent a lot of money to
12 upgrade our life packs to be able to
13 do wave form capnography, and many
14 of our life packs are too old to be
15 upgraded. So those that could be
16 upgraded are being updated by the
17 January 1 deadline. All of that
18 information of the wave form will be
19 able to be downloaded into the EPCR
20 system. There are a number, I think
21 about 30 or so life packs that
22 cannot be upgraded. So for --
23 actually, I've put those all in one
24 or two boroughs. For those we've

1 purchased stand-alone wave form
2 capnography monitors which -- and
3 the printers that are associated.
4 What it does is it prints out the
5 number every five seconds so you end
6 up with a strip that's, you know,
7 pages long, which isn't downloaded
8 into our EPCR system. So the
9 question becomes, you know, do we
10 save a little piece, snippet of that
11 versus save the entire strip versus
12 document on the PCR itself that wave
13 form capnography was used?
14 MR. WRONSKI: You always
15 document. If you have an old
16 machine that is incapable of
17 accepting the information, and we
18 also don't want encyclopedic
19 documents if we can avoid it, you
20 document carefully that you've done
21 this, that you've checked, that
22 you've monitored the patient, and
23 that will have to do for the moment,
24 but your system should build in a

1 process of replacement over time.
2 So I think, you know, we probably
3 need to have more conversation
4 off-line on this but, you know, this
5 will happen in some systems, and
6 we're not being unreasonable. You
7 just need to address it over time.
8 But with the understanding that if
9 you are tubing the patient, it is
10 expected that there be wave form
11 capnography as the standard to
12 assure.
13 DR. BILLITTIER: I have a
14 suggestion and then a question.
15 Since the -- it appears that this
16 will be designated as a standard of
17 care for EMS. I think this -- the
18 letter, or a similar letter, needs
19 to go out to the emergency
20 departments because it's not a
21 standard of care in the emergency
22 Departments or at least some that
23 I'm aware of right now. So I think
24 that is critical. But having said

1 that, I thought I remember reading
2 in a statute somewhere in New York
3 State that the Commissioner cannot
4 establish standard of cares in
5 medicine. I don't know how to -- if
6 that's true, and if so, how do you
7 reconcile with this?
8 MR. WRONSKI: What we
9 have is a specific area, all right,
10 under Article 30 that is in statute
11 and it allows this advisory body,
12 all right, the SEMAC -- the SEMAC to
13 issue an advisory guideline, okay,
14 with the approval and concurrence of
15 the Commissioner, which does help
16 establish a standard of care. You
17 know, my conversation with the
18 lawyers, that's the term they use
19 that helps establish a standard of
20 care. But I think it's because you
21 have a medical advisory body that
22 represents the EMS community which
23 is empowered in the statute very
24 clearly to establish standards of

1 care, and the Commissioner and the
2 advisory is the sign-off on the
3 advisory. In protocols, we
4 establish standards of care all the
5 time, so the first part of the
6 standard of care here is that in the
7 protocols it's the intubation. The
8 second part is, is how do you
9 confirm that? And advisory is
10 adding that weight to it but -- so
11 the piece that the Commissioner
12 can't establish the standard of care
13 of medicine may be the broader body
14 of medicine. They may not -- as a
15 matter of fact, I don't know of a
16 similar medical body that sits and
17 discusses standard of care in
18 physician medicine,
19 physician-delivered medicine, but
20 the statute clearly says that the
21 SEMAC, all right, in partnership
22 with the council protocols,
23 establishes the standard in EMS.
24 So, there is a limitation. You

1 know, when we say it's the standard
2 of care, we're applying it to the
3 EMS system. It may be recognized by
4 everyone that that really should be
5 the standard in hospitals too, but
6 our law is focused on the EMS system
7 and what we do in it, and it does
8 give us statutory power to establish
9 the standard.
10 DR. BILLITTIER: So it
11 might be, though, that my suggestion
12 can't be applied. In other words,
13 the Commissioner can sign off that
14 it becomes standard of care for the
15 EMS community --
16 MR. WRONSKI: Right.
17 DR. BILLITTIER: -- but
18 can't say it is an emergency
19 department.
20 MR. WRONSKI: I'll
21 actually ask that question because
22 it's interesting, but I do not
23 believe that what we do -- as a
24 matter of fact, I know that what we

1 do and rule on does not establish it
2 past the emergency room door.
3 However, what we do in EMS has often
4 in the past had an effect on
5 hospitals. So if the prehospital
6 system is doing this, I think it
7 will have an effect over time on
8 hospitals if they have a lower
9 standard in their hospital. But
10 I'll bring this up specifically to
11 bring it to the attention. And I
12 will tell you that one of our
13 medical directors in the Department
14 already brought this up with me and
15 said, you know, you're going to have
16 this on ambulances but not every
17 hospital. All the surgical suites
18 have it, that's my understanding.
19 So the surgery, the ORs all do it,
20 but it's not necessarily true that
21 all EDs have it. So, it's a
22 question. It's a good question.
23 DR. COOPER: I think
24 Dr. Billittier raises a very

1 interesting question. And again,
2 not to prolong this discussion, I
3 could be wrong, but my memory of
4 Article 30 is that nowhere in the
5 enabling statute for SEMAC, Section
6 3002a, as I recall, is the word
7 standard of care actually used.
8 What SEMAC is empowered to do is
9 establish treatment, triage and
10 transportation protocols and
11 standards for regulated medical
12 devices. I don't believe the words
13 "standard of care" are used. And
14 given the rather focused, legal
15 meaning of that term and the fact
16 that standard of care really does
17 imply a community standard among all
18 professionals involved in the
19 provision of care, I think this is
20 an area that really deserves some
21 clarification. I don't think any of
22 us around this table disagrees that
23 wave form capnography -- it is
24 clearly the ideal toward which

1 everyone should be striving who
2 cares for an intubated patient. But
3 use of the term "standard of care"
4 is fraught with -- with difficultly,
5 and I strongly urge the Department
6 to look into that issue and
7 hopefully choose its words very
8 carefully.
9 MR. WRONSKI: Yeah. The
10 words come out of an attorney's
11 mouth in discussions with me
12 directly. But what I'll do is, I'll
13 bring this, you know, this
14 conversation up with that attorney
15 who was assigned to give me advice
16 on this. Who was actually assigned
17 not to give me advice, give the
18 Commissioner advice, and he saw it
19 as the advisories help establish the
20 EMS standard of care. But we'll
21 certainly bring that up and discuss
22 it, and I'll come back in February
23 to give you that answer.
24 DR. COOPER: Certainly,

1 certainly no one would disagree that
2 the advisory guidelines, whether
3 from the SEMAC or the STAC, which
4 also has the statutory authority to
5 issue them, constitute Best
6 Practices in New York State. No
7 doubt of that. And I would suggest
8 that in your discussions with them
9 that term might be used.
10 DR. FUNK: Mr. Zeek.
11 MR. ZEEK: Wasn't the
12 SEMAC recently, in the last year or
13 so, empowered in statute to review
14 emergency department standards?
15 MR. WRONSKI: In the
16 Trauma regulations, they were
17 authorized to make recommendations
18 to modify regulations for hospital
19 emergency departments, right.
20 DR. FUNK: Is the Medical
21 Standards report complete?
22 DR. MARSHALL: Yeah. One
23 last -- one last item. Just for
24 your information, a couple of

1 meetings ago the issue of online
2 medical control came up and who was
3 actually on the other end of the
4 phone with the paramedic in the
5 field and the EMT in the field and
6 whether or not that person is an RN,
7 a PA, a nurse practitioner, or
8 another paramedic, or actually
9 critical care tech has also been
10 mentioned since yesterday. And so
11 currently under the statute, the
12 statute defines online medical
13 control as advice and direction
14 provided by a physician or under the
15 direction of a physician. It
16 doesn't go into what "under the
17 direction of a physician" actually
18 means, so we're going to be looking
19 at that at Medical Standards,
20 because actually, Dr. Dailey
21 presented some information yesterday
22 in the survey which actually showed
23 the 13 of the 18 regions that had
24 responded by yesterday was very

1 interesting, that about 54 percent
2 are actually connected to the
3 physician when they call for medical
4 control. Seven percent are
5 connected to a nurse, but there
6 seems to be that there might be a
7 physician nearby who is also
8 available. And 15 percent are
9 actually in contact with a paramedic
10 or a critical care tech. And again
11 it seemed from the information that
12 there was a doctor available, and 15
13 percent are put in contact with a
14 PA. So we're going to look at this
15 whole issue of what is under the
16 direction of a physician and who's
17 answering the phone and who is
18 giving the online medical control
19 direction. We do have a group of
20 people that have volunteered to look
21 into that and come back at the next
22 meeting with some information for
23 you. If you have any input, please
24 just let me know and I'll include it

1 in the next meeting.
2 DR. FUNK: Great.
3 DR. MARSHALL: That's my
4 report.
5 DR. FUNK: All right.
6 Well, I'll tell you what. Ten
7 minutes ago, I was going to give you
8 a ten-minute break, so you've got
9 five minutes, okay? Let's get back
10 so that we can all get on with our
11 Christmas shopping.
12 (A brief recess was taken.)
13 DR. FUNK: Is there
14 anyone who would like to give a
15 report from the Finance Committee?
16 Seeing none, we can move on. I'm
17 sorry to rush everybody. I know
18 that it's fun to get together and
19 chat, especially this time of year,
20 but there are other folks who have
21 other meetings at noon, and we are
22 scheduled to end at noon. I am
23 hopeful of that at this point, but
24 thank you for indulging me and

1 coming back to the table quickly.
2 Dr. McEvoy.
3 MR. MCEVOY: All right,
4 I'll talk really fast. The Finance
5 Committee met this morning,
6 actually, and a couple of items just
7 of note. We have no motions to
8 bring forward. The secretary has
9 the attendance. We did talk a
10 little bit about the budget template
11 and the current fiscal situation in
12 New York State, and I think the one
13 change that we're going to make with
14 that process is that we'll ask for
15 justification from the regional
16 councils and the program agencies
17 for any increase that they want.
18 Normally we use a COLA on that
19 template and ask for justification
20 beyond what the COLA is. And given
21 the current situation and not asking
22 for reductions, we're just going to
23 ask them to justify any increase
24 over what they had been allocated

1 for the previous -- this current
2 fiscal year.
3 We also had some continuing
4 discussion about funding for
5 courses. And as Mr. Wronski alluded
6 to, we had sat down with him and
7 discussed a little bit of the
8 current funding situation and the
9 EMS training moneys. And we have
10 been collecting data from the Bureau
11 and from core sponsors over the past
12 12 months to take a look at how that
13 is actually allocated. In other
14 words, what the funding levels are
15 for each one of the courses. It
16 would appear, at this point, that
17 there is a definite issue with the
18 funding for the BLS levels of
19 training, specifically the EMT
20 training, both at the refresher and
21 at the basic level. And so what we
22 plan to do at our February meeting
23 is actually to take a pie and look
24 at reallocating those funds from the

1 different levels and what effect the
2 influence of taking money from one
3 level would have on the other
4 levels. And we have enough data to
5 be able to play with that, you know,
6 "what if" type of scenario. And
7 based on that, we should probably in
8 February, or at least by June, be
9 able to make a recommendation to the
10 Bureau as to some changes in the
11 funding. And I want to just
12 emphasize that it appears, despite
13 the fact that we're rolling back
14 money out of the training portion of
15 the budget, that that rollback has
16 become less and less to the point
17 now where we appear to be using in
18 the training fund, pretty close to
19 what we're allocated. And I don't
20 think anyone, including myself,
21 would expect that that number is
22 going to increase. So when we're
23 doing reallocation, we're basically
24 looking at the pie that we have,

1 what we're spending and seeing some
2 ways that that might be used more
3 efficaciously. That's the end of my
4 report.
5 DR. FUNK: Thank you. Are
6 there any questions?
7 MR. WRONSKI: Just a
8 comment of -- Dr. McEvoy and
9 Mr. Bishop had talked to me about
10 this, and it's a legitimate area for
11 discussion and certainly concern. I
12 want to make sure our sponsors are
13 capable of being funded in a manner
14 that makes them financially
15 supported to do their job. The key
16 is, I'll remind everybody, is that
17 the dedicated fund was established
18 in two parts. One was to support
19 the State and regional EMS
20 organizations. This body is one of
21 them. And the other half of the pie
22 was to support education but very
23 specifically, very specifically, to
24 support that there be an EMT with a

1 patient on an ambulance. That was
2 the primary goal ultimately with
3 that fund, and that leftover funds
4 were to be allowed to support
5 advanced life support services when
6 there were left over funds. And so
7 in a reallocation that has to be
8 kept in mind. All right? That
9 basic life support, the EMT on the
10 ambulance, is the primary
11 legislative mandate for that fund.
12 It always was. And I know this
13 because I've had lots of
14 conversations over time with
15 different legislative members who
16 were part of the process. And one
17 of them, who was the assistant to
18 the Speaker of the Assembly, pointed
19 that out very directly to me and
20 said, We did this, and we gave funds
21 for EMS so that there would be an
22 EMT on an ambulance with a patient.
23 Everything else was gravy, but that
24 was the reason, and so there are no

1 if's, and's, or but's on that. So
2 when we work with reallocation, we
3 have to keep that core principle in
4 mind. Thank you.
5 MS. GEIGER: Ed referred
6 earlier to our reappropriation
7 authority if we should have untapped
8 funds from our base EMS account.
9 Again, those reallocated funds must
10 be used for education and training,
11 and they are primarily supporting
12 our advanced life support education
13 in New York State right now. And
14 some of you around this table may
15 remember a time when we did not have
16 those reappropriated funds, so we
17 are very careful to make sure we
18 work with our partners in the
19 Division for the Budget so those
20 funds are used appropriately.
21 DR. FUNK: Thank you. Any
22 other questions for Finance? Ms.
23 Fults, Education and Training
24 report, please?

1 MS. FULTS: Thank you.
2 The first thing I would like to do
3 is to thank Education and Training
4 Committee. All of the TAGs and the
5 chairs of the TAGs and the Bureau of
6 EMS staff that are assigned to
7 Education and Training for the hard
8 work that they do every year. It's
9 not in any of our committee meetings
10 that you do not hear the term
11 "education" or "training" come up
12 several times in a meeting, all the
13 way from Medical Standards to
14 Finance. We hear everything as far
15 as education, education and
16 training. It's through the hard
17 work of that Committee and the
18 challenges that they face and the
19 accomplishments that they complete
20 each year to do the goals that we
21 set forth at the beginning, and I am
22 deeply thankful to that committee
23 and all their hard work. Thanks to
24 Mr. Wronski and Dr. Marshall, I have

1 a short report now, so --
2 DR. FUNK: I would like
3 to just interject we heard yesterday
4 that you have been leading that
5 committee for five years, and just
6 want to congratulate you on leading
7 such an effective committee.
8 MS. FULTS: Oh, thank you.
9 DR. FUNK: It's been
10 wonderful.
11 MS. FULTS: Thank you.
12 It's really the committee, it wasn't
13 me.
14 So I'd kind of like to just
15 leave this year with where the
16 committees are at. And the SCT TAG
17 has kind of re-emerged. Mr. Wronski
18 will set up a meeting with DOH
19 hospital division and TAG
20 representatives to discuss issues
21 related to SCT training and clinical
22 sites.
23 The CLI curriculum TAG is
24 updating the 1989 CLI curriculum.

1 The online course TAG is finishing
2 up their work and will be putting
3 forth the recommendations to
4 Education and Training at the
5 February meeting for a proposed
6 model to be considered by New York
7 State DOH. The Safety TAG gave an
8 update, and again, has reiterated
9 the need to stress safety in our
10 courses.
11 We have a group that is
12 looking at the national educational
13 standards and the instructional
14 guidelines at each level, from CFR
15 all the way through to paramedic.
16 They're still continuing their
17 review. That is a long and lengthy
18 process. And to let everybody know,
19 that all the instructional
20 guidelines are now available at
21 every level on the NEMSIS site.
22 I just want to add one thing
23 onto what Mr. Wronski said about the
24 testing for possibly January through

1 May of next year. That is really
2 important to take back to your core
3 sponsors, to get their applications
4 in early. Try not to wait 'til that
5 six-week -- six weeks before the
6 test date so that just in case there
7 isn't a meeting, I mean -- excuse
8 me, there isn't a test in January or
9 March, that they have an idea how
10 many people will be testing when
11 there is a test date. Which brings
12 me into the second part of that, to
13 take back to the core sponsors and
14 to your certified instructor
15 coordinators to review those
16 applications before they mail them
17 in. There is like a 15 percent
18 error on those applications, of the
19 ones that are sent in. We need to
20 check them over. And Gene Taylor
21 told us the common things that
22 people make mistakes on are the EMT
23 numbers, their number that they put
24 on, or don't put on their

1 application. They forget to write
2 in the state. Even though we're
3 from New York State, you still need
4 to write in New York State. And the
5 other thing is, there is a lot of
6 people that test in the year that
7 they're born, the date of birth. So
8 that starts when the CIC collects
9 those applications. They should
10 review them and the core sponsor
11 should review them because that just
12 delays time for those to be in the
13 system.
14 Does anybody have any
15 questions for Education and
16 Training? That really is all of my
17 report. Thank you again for such a
18 great year.
19 DR. FUNK: Thank you
20 again. Any other questions or
21 comments?
22 MR. FAETH: Thank you,
23 Dr. Funk. PIER comes to this body
24 with no seconded motions. Donna

1 Gerard gave the staff report and
2 states that Vital Signs did very
3 well this year. We had
4 approximately 600 -- 1,600, I'm
5 sorry, attendees. It was a little
6 less than what we've had in previous
7 years. I think that's a product of
8 the economy. We'll be seeing that
9 kind of trend across the country. I
10 want to thank everyone that assisted
11 us with the State booth and the
12 SEMSCO booth. We had -- we had full
13 coverage, and we greatly appreciate
14 everybody that stepped up to assist
15 us.
16 The 2009 dates that you might
17 want to mark down in your calendars,
18 we have, EMS week will be held from
19 May 17 to the 23rd. We have a
20 tentative date for the state
21 memorial on that Wednesday, May
22 20th. That obviously is not in
23 stone. That will have to be
24 coordinated with the Commissioner's

1 office, so just, you know, put
2 question marks next to that on your
3 calendar, but we would really like a
4 large turnout this year, as it
5 should be every year. Vital Signs
6 next year will be held in Rochester,
7 and the dates for that will be
8 October 15 through the 18th, and
9 again we would really appreciate
10 everybody that can talk that up in
11 your region and if each of you can
12 make it, that will be great. It
13 makes for a better event. And Ed
14 had given the dates for the Vital
15 Signs for these meetings over at the
16 Crown Plaza, a new venue, and it
17 should work out well.
18 The EMS memorial,
19 unfortunately we do have two new
20 inductees for this year coming
21 forward: Mr. Norman Haynes, who
22 passed away in July of '07 and
23 Mr. Edward Muller who passed away in
24 February of '08. We will be

1 honoring their sacrifice and their
2 commitment to EMS.
3 We have updates on the do's
4 and don'ts, as you know, from the
5 last meeting produced. The
6 Department of Health has numerous
7 copies of that. Anybody that would
8 like to have copies for their region
9 or their agency, just contact Donna
10 or Valerie. We would be happy to
11 distribute them to you. People have
12 been picking them up. There were
13 some available earlier here at the
14 meeting.
15 We're moving forward with
16 doing the recruitment video. Due to
17 the huge undertaking that that would
18 be, the cost factors, we are going
19 to be approaching one or several
20 film schools either in New York City
21 or up in this region. Someone
22 who -- that would like to undertake
23 this, we're going to give them the
24 structure of the script, and

1 hopefully they'll be able to produce
2 it at a low cost for us. We look
3 forward to that. We've reviewed
4 other videos that are available out
5 there. There was only one out of
6 numerous ones that we saw that we
7 felt was of a decent production, but
8 we're still considering other
9 options. That would be focused for
10 the high school students to try to
11 promote EMS and their interest in
12 coming into this field.
13 We're also looking at doing a
14 new recruitment poster. The
15 previous poster, as all of you know,
16 was compiled -- made basically of a
17 drawing, painting. The one that
18 we're going to put together now is
19 going to be a collage of actual
20 photos of, hopefully, as many
21 systems and agencies that we can put
22 together and fit on a poster from
23 across the State. So, what I am
24 requesting of this body, and anybody

1 in the audience, if you have any
2 good photos, digital photos, that
3 you can e-mail me with, that depicts
4 your agency or what you do, whether
5 it be air med or whether you're from
6 a commercial, municipal, voluntary
7 aspect, fire, police, we would like
8 representation of all the different
9 regions that we can acquire, and we
10 would have the graphics personnel
11 over at the Department of Health put
12 that together into a poster form
13 and, hopefully, we will have a
14 product before the end of this year.
15 So, if you take out your crayons and
16 write down my e-mail, that's
17 uep2507v, as in Victor, p, as in
18 paramedic, @AOL.com. That's
19 uep2507vp@aol.com. I'd appreciate
20 any, you know, any files you can
21 give me, and we can move forward
22 with that.
23 Also, let's see, we're still
24 working on the school play, and that

1 concludes my report.
2 DR. FUNK: Thank you. Any
3 questions for PIER? I'm going to
4 skip Evaluation just for a moment so
5 that we can get Mr. LaMarca and
6 Systems on.
7 MR. LAMARCA: The Systems
8 Committee met yesterday and the
9 secretary has the attendance. There
10 are no seconded motions.
11 We did hear briefly from our
12 Communication TAG, which is still
13 striving to get some returns on
14 their survey to give us a report at
15 our next meeting. They are a little
16 overdue for the Safety TAG, which
17 I'll show you here later.
18 Our EMS Code Review TAG is
19 actually, by mutual agreement, going
20 to be deactivated at this point in
21 time and when and if necessary will
22 be reconstituted, I guess, to handle
23 any matters that come up.
24 There were no pending CON

1 issues, no new appeals filed.
2 According to the staff report given
3 by Miss Burns, there was a recent
4 issue with municipal CONs which, in
5 the Hudson Valley, there were three
6 municipalities that had incomplete
7 declarations of the muni CON end
8 process. And the problem, I guess,
9 originated where a commercial
10 service was providing care in those
11 areas and was not licensed to
12 operate in those areas at the time.
13 So, during the investigation it
14 appears that the Department did
15 bring this to the attention of the
16 Office of Medicaid Management, or
17 OMM, and also the Office of Medicaid
18 Inspector General, due to
19 inappropriate billing from that
20 service in an area outside of its
21 statutory geography.
22 I would just like to further,
23 I guess, in discussions with Office
24 of Medicaid Management and the

1 Office of Medicaid Inspector
2 General, and the Department is
3 trying to, you know, right now get a
4 handle on exactly how many services
5 are billing. It does appear that,
6 out of the 1,095 currently certified
7 ambulance services, about 370
8 ambulance services from the OMM
9 report are actually billing and
10 another 31 hospitals have a Medicaid
11 provider I.D. number, allowing them
12 to bill for ambulance transportation
13 and then only 84 of those service
14 are actually commercial providers.
15 So there has been ongoing meetings,
16 I guess, with representatives of the
17 Bureau and the Office of Medicare --
18 Medicaid Management, excuse me, to
19 look at some of these issues because
20 they do pose some risk to some of
21 the services inasmuch as -- if
22 there's inappropriate billing that's
23 been done accidently or certain
24 billing companies have not filed for

1 the proper paperwork. So again, as
2 we pointed out yesterday it's
3 probably wise for all billing
4 services, procedures, and if they
5 have any questions try to seek out
6 the appropriate authorities in
7 Medicaid and Medicare.
8 To read into the record, we
9 did have one EMS service surrender
10 its operating certificate to the
11 Department, and it's the Eastman
12 Kodak Company's ALS first response
13 unit. And we have two municipal CON
14 filings; one from the City of
15 Cordeval (phonetic) Fire District
16 that are ongoing. Lee also brought
17 out that, just as an advisory, that
18 controlled substance licenses lapses
19 still remain a bit of a problem, and
20 that they reviewed the list and
21 determined that there were 30 that
22 listed as lapsed but only 4
23 services, you know, I guess were
24 notified. Three of the four have

1 submitted renewal applications. And
2 that was pretty much it. You've
3 heard some of the other elements in
4 other reports.
5 DR. FUNK: Any questions
6 for Mr. LaMarca? It's being pointed
7 out to me that you've been sitting
8 with us for long enough that we're
9 not going to want you back, or
10 something like that? I'm being told
11 that this may be the end of your
12 term?
13 MR. LAMARCA: That's Al's
14 term.
15 DR. FUNK: Is that true?
16 MR. LEWIS: That's true.
17 DR. FUNK: No, nobody is
18 leaving, that's it. Well, thank you
19 very much for both of your time.
20 But Al, if this is going to be the
21 end of your term with us as the
22 ONYON rep, we certainly would not
23 want to go by without recognizing
24 your efforts here. So, thank you

1 very much. And if you would like to
2 give your report next?
3 MR. LEWIS: Sure. Very,
4 brief. I, too, would like to thank
5 our committee for their
6 participation throughout the year.
7 We have had great support from many
8 different agencies, and it has been
9 very beneficial for them to be at
10 the table sharing their legislative
11 initiatives throughout 2008.
12 We have no seconded motions
13 coming before you today. The
14 sign-in sheet was shared with the
15 secretary for yesterday's meeting.
16 The only thing I would ask, we did
17 share also yesterday the number of
18 legislative initiatives that were
19 supported not only by the
20 Legislative Committee, they were
21 brought to SEMSCO and also endorsed
22 here, and some have been signed by
23 the Governor into law. But I would
24 ask in 2009, for the incoming chair

1 and the Bureau to remain focused on
2 paramedic permanent certification or
3 licensure. I believe that that TAG
4 was chaired by Mr. Zeek who did a
5 great job bringing forth a lot of
6 interesting points. I think it's
7 worthy of further study with the
8 Department of Education. It's
9 unclear as to whether permanent
10 certification or licensure makes the
11 most sense, but there may be both
12 available to those paramedics that
13 choose to be licensed versus
14 certified. I know of many in my
15 business that have been taking those
16 tests every three years or going
17 through the pilot programs for 25 to
18 30 years. It gets to a point where
19 we may lose them or would lose them
20 because there is no permanent
21 opportunity for certification or
22 licensure for them. They are
23 valuable to us. If we were to lose
24 the long-time paramedics right now,

1 our system would be in very poor
2 condition, so I encourage us to
3 remain focused on that in 2009. I
4 did talk to Mr. Faeth, and I'm
5 hoping that that can stay on the
6 agenda. And thank you very much for
7 your support for all these years.
8 DR. FUNK: Thank you. So
9 we continue down the list. Was
10 there anybody else that approached
11 me, that I've forgotten about, that
12 needs to leave on time? Well, let's
13 go with Safety then.
14 MR. DARBY: The Safety
15 TAG did meet yesterday afternoon, 17
16 present.
17 At the Vital Signs Conference,
18 we have achieved the ability of
19 doing a presentation. It was
20 scheduled at Track E Sunday
21 afternoon. My co-chair, Paul
22 Bishop, gave a presentation called
23 "Join the Revolution, Steps to
24 Create a Safe EMS Workplace" which

1 was the charge of the TAG. He ran
2 the meeting yesterday, so I will
3 turn over the rest of the report to
4 Paul.
5 MR. BISHOP: Thank you,
6 Mr. Darby. I want to just highlight
7 two quick items that are going on.
8 One is strengthen policy statements.
9 One was released over the summer
10 about passenger restraints in
11 vehicles, and the other is a
12 visibility standard for all workers
13 who may be on the highway. I guess
14 the easiest way to sum it up is, if
15 your feet are on the street, a vest
16 should be on your chest. But if you
17 want to go into greater detail,
18 regulation is available on the
19 Bureau website.
20 I want to compliment Lee Burns
21 and the work of other bureau staff.
22 I'm pulling together a data
23 collection instrument for Part 800,
24 Reportable Incidents. We all have a

1 requirement under Part 800 to report
2 certain times when vehicles are in
3 crashes, providers are injured, or
4 patients are injured, but there has
5 not been a great data collection
6 system, and I must say, if the
7 system comes out as it's being
8 described and the work that's
9 happening so far, it will be a
10 dramatic improvement. So, we'll be
11 able to track when our providers are
12 injured, when our patients are
13 injured and when the incidents
14 occur. So hopefully, we'll be able
15 to reduce those circumstances in the
16 future, and the hope is to have that
17 come out the first quarter of 2009.
18 And finally, one of our TAG's
19 activities for next year will be to
20 produce a Best Practices paper that
21 we can share across EMS and our
22 state and will be a living document,
23 as safety is constantly changing,
24 but an important part of getting

1 people to accept the message and to
2 really -- and being safe. Thank
3 you.
4 DR. FUNK: Thank you.
5 Any questions for Safety? We'll go
6 back to Evaluation.
7 MR. DELAGI: Thank you,
8 Dr. Funk. On behalf of my co-chair,
9 Dr. Kaufman, I'd also like to extend
10 a hearty thank you to our Evaluation
11 Committee for all the fine work that
12 they have done this past year.
13 You'll hear throughout the report
14 some of our products have actually
15 come to a conclusion, some have been
16 extended to 2009.
17 On behalf of the Committee, we
18 would also like to extend our
19 congratulations to Marjorie on her
20 new appointment and to thank her as
21 the staff person assigned to our
22 committee. She was invaluable in
23 providing a steady hand of the
24 systems throughout all of our

1 projects. So, thank you, Marjorie
2 and good luck to you.
3 We had our meeting yesterday.
4 The secretary has the attendance.
5 No seconded motions to come forward.
6 Our meeting was opened up by
7 Mr. Brian Gallagher from the School
8 of Public Health, who gave us a very
9 insightful presentation on the 2006
10 PCR data which has two milestones.
11 For the very first time, it includes
12 more than a million calls from New
13 York City which greatly enriches the
14 out-of-hospital care database, and
15 it also includes a co-mingling of
16 out-of-hospital data with
17 in-hospital data from the SPARCS
18 database, and that will give us the
19 opportunity, going forward, to track
20 patient outcomes and compare
21 prehospital impressions or
22 presenting problems with outcome, so
23 we're very excited about that.
24 In the 2006 database, there

1 were more than 2,368,000 records
2 entered, and the analysis that we
3 saw included demographics on the
4 type of call, the call disposition,
5 the primary presenting problem,
6 information on gender, mean response
7 times and a comparison in terms of
8 increases or decreases by region
9 from a period of 2002 to 2006, and
10 that was very interesting to see.
11 We're told that the 2006 data will
12 be released to the regions shortly,
13 and in 2009, sometime throughout the
14 year, we'll anticipate that report
15 which will combine the in-hospital
16 and out-of-hospital data for us.
17 We learned in the staff report
18 that the Bureau was fortunate to
19 receive a Governor's Traffic Safety
20 Board Grant, which we had spoken
21 about several meetings ago, and that
22 is important to us on two fronts
23 because it's tied to our initiative
24 to promote NEMSIS compliance here in

1 New York State and tied to the
2 opportunity to have a statewide
3 electronic data-receiving portal.
4 It's a three-year grant, and over
5 the course of the three years it
6 will start off with investigating
7 the internal operating systems,
8 establishing a data-collection
9 portal and leading to basically
10 modifying the internal processes to
11 fund several corroborative projects
12 between REMACs and RTACs so that we
13 can begin to collect data in an
14 electric format. It's important to
15 remind everybody on the record that
16 this grant does not provide funding
17 to staff, nor does it provide
18 funding for equipment for
19 distribution to regions. This is
20 simply to develop an electronic
21 receiving portal for the many
22 different electronic reporting
23 formats used across the region.
24 The Department of Health was

1 working with the New York
2 Agriculture Health Center, using
3 recent PCR data from ten rural
4 counties, to investigate
5 farm-related occurrences with the
6 goals of enhancing epidemiology
7 investigation of farm-related
8 injuries and hoping to impact that
9 by employing prevention strategies
10 going forward.
11 In concert with the Air
12 Medical TAG, we did complete our
13 work on helicopter utilization, and
14 I just wanted to share with you some
15 interesting findings from that
16 report. As I go through this,
17 please keep in mind that the goal of
18 this survey was very narrow in scope
19 and it was very simply to determine
20 the volume and types of patients
21 utilizing air medical services in
22 the State and if those requests for
23 air medical services were consistent
24 with the New York State DEMS policy

1 05-05, which are guidelines for
2 helicopter utilization. And it was
3 very narrow in scope, so as we talk
4 about some of the things that we
5 found with regard to where patients
6 and the outcome at different types
7 of hospitals, that was not something
8 that we looked at, but it's
9 something that we will look at going
10 forward.
11 We identified very clearly
12 some limitations. This obviously
13 was a clinical study. We believe
14 that there is a very likely
15 possibility of underreporting, since
16 we do not have access to the total
17 number of flights statewide in the
18 study period for comparison. But we
19 did take a look at identifying
20 overlapping patient conditions that
21 led to finding that the vast
22 majority of cases received contained
23 both multiple anatomic or
24 physiologic conditions and/or

situational criteria. If you think
about the perception of using a
helicopter to get a multiply
traumatized patient to a hospital
quickly, that seems to make perfect
sense.

So in the study period, which
actually went from March 1 to May
31, there were a total of 513
flights logged into the database.
And we found that abnormal Glasgow
Coma Scale emerged as the major
physiologic reason for patients
being flown to trauma centers.
Adult trauma cases far outweighed
all other types of cases by a
significant margin. Adult trauma
cases made up 70 percent of the
flights. Pediatric trauma cases, by
comparison, came in at nine percent.
Medical cases, which were actually
almost evenly split between cardiac
and stroke, had eight percent.
Critical burns had four percent and

1 flights that did not meet criteria
2 at five percent. And we thought,
3 that given the information that we
4 had, let me just share with you one
5 other statistic before I move on,
6 and that was that the majority of
7 cases, 98 percent of them, were
8 flown to trauma centers, 80 percent
9 to Level 1s and the remaining to
10 Level 2s, collectively, meaning 98
11 percent going to trauma centers by
12 comparison to 2 percent of cases
13 flown to non-trauma centers. So,
14 when you take a look at that very
15 brief snapshot, it's certainly
16 reasonable to suggest that the
17 utilization of EMS in New York State
18 is indeed consistent with the
19 published guidelines. And that led
20 to some new initiatives to work with
21 STAC on outcome of patients who went
22 to Level 1 centers versus Level 2
23 centers to see what has gone on with
24 regard to those patients, to see if

1 we can come up with a way to look at
2 time and distance with regard to how
3 helicopters are used, and to compare
4 some of the softer outcome, some of
5 the softer criteria, particularly
6 situational and mechanistic as it
7 relates to the safety of using
8 helicopters. As you know, there
9 have been a spade of air medical
10 crashes over the last couple of
11 years and more recently over the
12 past couple of months. You take a
13 look at that variable, you take a
14 look at the variable that
15 includes -- area trauma centers
16 going out of service because they're
17 unable to maintain essential
18 services. We need to take a look at
19 everything with regard to that, from
20 a safety perspective, to see if
21 we're utilizing our helicopters
22 appropriately.
23 Any questions or discussion on
24 that before I go on? Okay. Seeing

1 none, I'd like to ask Sharon
2 Chiumento to briefly talk to you
3 about the QI survey results. You
4 recall that we did a survey at this
5 past Vital Signs Conference where we
6 asked providers to give us some
7 information as they understand the
8 QI process and as it related to our
9 rollout effort. And we thought it
10 was important just to share this
11 snippet with you, because as you
12 will see, the data certainly
13 suggests that we all need to go back
14 to our respective regions and
15 continue to embrace QI at the agency
16 level and continue to promote the
17 use of the manual and the use of the
18 QI process with our agency folks
19 back home. Sharon?
20 MS. CHIUMENTO: Thank
21 you. There were 268 surveys that
22 were completed. There was at least
23 one for each region with a maximum
24 of 40 from the Suffolk County

1 region. All levels of providers
2 were represented. Most of them,
3 however, greater than 50 percent
4 were EMTs and 30 percent were
5 paramedics and the rest were
6 distributed among the rest of the
7 certification levels. You will
8 notice that the agency QA
9 coordinators, there was yes, no,
10 unknown, so people marked off
11 unknown as a category choice and
12 then not filled out at all was that
13 last column. Ninety-four percent of
14 the agencies said that -- or the
15 papers said that there was a QA
16 coordinator, that they knew there
17 was an agency QA coordinator. The
18 second percentage in each category
19 is a total of the entire number.
20 The first one is of -- the first
21 percentage is of the yes/no answers.
22 Ninety-four percent of yes/no
23 answers indicated that there was a
24 medical director. Seventy percent

1 of the agency committees' -- yes/no
2 answers indicated that there was an
3 agency committee. Seventy-six
4 percent indicated that there was a
5 QI plan at their agency.
6 Eighty-seven percent indicated that
7 there was agency call review.
8 Seventy-four percent indicated that
9 there was QA feedback by their
10 agency. Seventy-three percent said
11 that their agency did QI education,
12 and the last number, which we
13 expected to be a little smaller
14 because of the fact that the manual
15 just went out last year, 55 percent
16 said that they were aware of the New
17 York State manual. Then there were
18 regional variations but we won't go
19 into that. Keep it brief.
20 If we go down to the QA/QI
21 initiatives portion, we actually
22 asked them what they thought. So
23 for the 146 people who looked at the
24 manual, what did they think of it?

1 And so, you'll notice that they
2 evaluated the ease of use, whether
3 or not it could be used a QI
4 pathway, whether they liked the
5 suggestions in the manual, tools in
6 the manual, charts in the manual.
7 And all of them were very useful,
8 either highly or somewhat useful, so
9 it was a very high percentage of
10 those who had seen the manual,
11 feeling that it was of use to them.
12 The most useful thing being the
13 suggestions in the manual.
14 And the last thing that was
15 evaluated was whether or not they
16 attended a DOH rollout or not, or a
17 local rollout of the manual. And
18 you'll notice the numbers were
19 relatively small. Only 23 percent
20 had attended a Department of Health
21 rollout; 27 percent had attended a
22 local rollout. So, and there is,
23 you know, more need for it to get
24 out to the providers who feel that

1 probably agency administrators are
2 more aware of it but the providers
3 probably are not as aware -- or have
4 not had a chance to see it, so we
5 need to do a little bit more work in
6 that area.
7 And then the only other thing
8 that we did ask them about was what
9 they saw were barriers to QA/QI in
10 their region or in their agencies.
11 There was 78 different barriers
12 noted. The most common ones were
13 time constraints, lack of staffing,
14 leadership issues, lack of
15 communication, lack of participation
16 or interest, limited knowledge or
17 training, no agency review of calls,
18 administration or others were not
19 supportive, attitude, limited
20 resources, poor or no feedback, or
21 volunteer mentality. And the rest
22 of the responses had less than five
23 responses, so I didn't list those
24 there.

1 Any questions?
2 MR. DELAGI: It's always
3 nice to go near the end of the
4 meeting. It keeps the questions
5 down.
6 Sharon, just so everybody
7 knows -- and Sharon, again, thank
8 you. She has volunteered to create
9 an executive summary which we'll
10 actually distribute to all of the
11 services throughout the region, or
12 at least through the regional
13 councils in -- to make everybody
14 aware of these results in the
15 furtherance of the process.
16 MR. WRONSKI: Can I make
17 a comment?
18 MR. DELAGI: Please.
19 MR. WRONSKI: What you
20 saw in the survey was an outreach by
21 the Council, really, to understand
22 participation in QI, understanding
23 of QI, and not just simply this
24 manual. The -- since 19 -- I think

1 it's '98 or '96, I forget, '98 or
2 '96 --
3 SPEAKER: '96.
4 MR. WRONSKI: -- '96,
5 thank you, QI was required of every
6 ambulance service in the State of
7 New York, and it varies as to how
8 many actually do it in -- way. And
9 so we came out originally with a
10 document produced by the SEMAC and
11 State Council which was helpful in
12 kicking off and understanding, and
13 then this document, which is a
14 modern review of QI and is an
15 additional tool for services, but I
16 think the survey is giving us some
17 information about how much has been
18 implemented or not and how much it's
19 understood and that while clearly
20 there are -- there is an
21 understanding, more of an
22 understanding today in EMS of QI
23 than there used to be, there needs
24 to be a lot of work still done, and

1 we really do need to, at our
2 regional level, and at the state
3 level, continue to promote good
4 quality improvement practices. So,
5 you know, I commend all this work.
6 It all has a real benefit to the
7 system.
8 MR. DELAGI: Thank you.
9 Just a couple of other quick items.
10 We reviewed the -- this year's
11 annual QI studies submitted by
12 program agencies to look at the
13 abstracts. We've seen 15 abstracts,
14 15 different program agencies, and
15 we're continuing to go through some
16 of the final reports from last
17 year's QI study that were submitted.
18 The work with the New York
19 ACEP on the report card continues.
20 We have not seen a draft of that
21 document yet, but we expect that to
22 come out late December or early
23 January. We actually await that.
24 And concurrently we continue to work

1 on collecting data in the seven
2 areas that we've previously
3 identified as key areas and take a
4 look at the state of EMS in New York
5 State. Some of the projects have
6 already been completed, others are
7 ongoing. We actually hope to have a
8 comprehensive report prepared for
9 you prior to the February meeting.
10 We'll actually have seven chapters,
11 each chapter for each of the data
12 points and kind of give you a
13 snapshot of where we are. And that
14 is my report, unless there are any
15 questions.
16 DR. FUNK: Questions? If
17 there is no objection, again I know
18 that we're going to be losing
19 several people who have other
20 meetings that they have to attend.
21 So before we do have to say goodbye
22 to those folks, if you don't mind,
23 we can do elections now so that we
24 have everybody at the table to be

1 able to do that and then we'll
2 complete the reports. Any
3 objections to doing it that way?
4 Okay. Mr. McEvoy, would you like to
5 lead us off?
6 MR. MCEVOY: Sure. As I
7 said at the last meeting, the
8 Nominating Committee -- which
9 consisted of Mike Quinn, Warren
10 Darby, and myself -- has proposed a
11 slate of officers for next year for
12 SEMSCO. And that slate of officers
13 was Don Faeth, as chairperson,
14 representing the uniformed EMTs and
15 paramedics of FDNY; the first vice
16 chair, Robert Delagi, representing
17 the Suffolk County REMSCO; and
18 second vice chair, Timothy
19 Czanpranski, representing Monroe
20 Livingston REMSCO. So, I guess, if
21 I do those one at a time, we can do
22 those by vote. And I would start
23 with the chairperson and ask if
24 there are any nominations from the

1 floor for the office of chairperson.
2 And I'll ask again if there are any
3 nominations from the floor for the
4 office of chair? And ask for a
5 third time if there are any
6 nominations from the floor for the
7 office of chairperson? We'll take a
8 motion to close those nominations.
9 Moved by Dr. Cooper and seconded by
10 Mark Zeek. And I would accept a
11 proposal for the secretary to cast
12 one ballot for Don Faeth as
13 chairperson. All in favor?
14 SPEAKERS: (Series of
15 ayes.)
16 MR. MCEVOY: Any opposed?
17 So, congratulations to Don.
18 MR. FAETH: Thank you.
19 MR. MCEVOY: Maybe
20 condolences. For the first vice
21 chair, I'll ask if there are any
22 nominations from the floor for the
23 office of first vice chair? Ask
24 again if there are any nominations

1 from the floor for the office of
2 first vice chair? And ask a third
3 time if there are any nominations
4 from the floor for the office of
5 first vice chair? I'll take a
6 motion to close the nominations.
7 Mike Washington, seconded by Edgar
8 Wedge. All in favor?
9 SPEAKERS: (Series of
10 ayes.)
11 MR. MCEVOY: And I'll
12 accept a motion for the secretary to
13 cast one ballot for Dr. Cooper,
14 seconded by Mark Zeek. All in
15 favor?
16 SPEAKERS: (Series of
17 ayes.)
18 MR. MCEVOY: And any
19 opposed? Well, congratulations.
20 MR. DELAGI: Thank you.
21 MR. MCEVOY: Maybe
22 condolences to Bob. And for the
23 second vice chair, I'll ask if there
24 are any nominations from the floor

1 for the office of second vice chair,
2 any nominations from the floor, and
3 calling for a third time, any
4 nominations from the floor? I'll
5 accept a motion to close the
6 nominations from Dr. Cooper,
7 seconded by Mark Zeek. All in favor
8 of closing the nominations? Any
9 opposed? And I'll accept a motion
10 to have the secretary cast one
11 ballot from Edgar Wedge, seconded by
12 Dr. Cooper. All in favor? Any
13 opposed? Congratulations to -- Tim
14 Czanpranski. So, congratulations to
15 all the officers for 2009. Thank
16 you.
17 DR. FUNK: Thank you very
18 much. I guess I'm done now. I
19 think we do have two other items. I
20 think we heard a great deal from
21 EMSC but is there anything else that
22 folks from EMSC would like to share
23 with us from their report?
24 DR. COOPER: We meet

1 tomorrow, so we'll have to get back
2 to you in the new year.
3 DR. FUNK: Back to my
4 successor. How about the State
5 Trauma Advisory Committee? Is there
6 anything from Trauma? Do you have
7 anything? Okay, then any unfinished
8 business? Okay.
9 DR. COOPER: For the
10 State Trauma Advisory Committee I
11 think probably the main two
12 issues -- Dr. Henry, please, if
13 there is anything you recall that
14 should be brought up, please do so,
15 but the group that is working on the
16 final version of the Trauma
17 regulations will be meeting in
18 January and bringing presumably a
19 final package back to the STAC in
20 March. And I think Mr. Wronski
21 already reported on the issue of
22 trauma center closings which
23 continues to be a very -- one, and
24 the STAC continues to worry a great

1 deal about that. The STAC also, as
2 I recall, did ask Dr. Henry to -- or
3 Dr. Marx, excuse me, to write a
4 letter similar to the one that
5 Dr. Henry and Dr. Funk will be
6 writing with respect to Doctors
7 Across New York and the shortages of
8 trauma surgeons in various areas.
9 Mark, do you recall anything
10 else of major substance that should
11 be mentioned?
12 DR. HENRY: Those are the
13 main things.
14 DR. FUNK: Unfinished
15 business? New business? Well, then
16 --
17 MR. FAETH: I do have one
18 item under new business. I think I
19 can take the liberty to speak for
20 the body here. I want to thank you,
21 Dr. Funk, for your leadership. We
22 all greatly appreciate what you've
23 done for us. You've -- personal
24 responsibilities -- you know, family

1 at home, being a physician in your
2 region. You have always been
3 available for any assistance to any
4 of our members that need it. You've
5 acknowledged the issues, and you've
6 always been of assistance to us, and
7 you've been valuable in your
8 leadership, and we greatly
9 appreciate that. And if we could
10 just ask the stenographer to go off
11 the record for a moment?
12 (Discussion was held off the
13 record.)
14 DR. FUNK: I would like
15 to go back on the record and say
16 thank you. This is -- this is
17 really wonderful. I do want to say
18 my own thanks. It really has -- I
19 can't see past this -- it really has
20 been a pleasure. You know, there
21 are certainly a lot of things that
22 folks could say about
23 responsibilities such as this, but
24 it has been a pleasure to be sitting

1 in this chair and to have your
2 confidence and your friendship. I
3 want to thank Ed, Marjorie, and
4 Donna, specifically, and the entire
5 bureau staff, probably mostly
6 unrecognized, but they hold this
7 council together. And I, certainly,
8 and I know that all of you folks do
9 appreciate that. I know that it has
10 been a challenging year at this
11 table and at home for a lot of us.
12 So thank you for all of the time and
13 the effort that you've put forth
14 here. So, thanks for your
15 confidence and your hard work here
16 in this room, whether you're vetted
17 or pending, thanks for still being
18 here. Most of all, thanks for your
19 friendship, and I hope you all have
20 a happy holiday season and God bless
21 you.
22 MR. WRONSKI: Okay, just
23 one last follow-up to your basket.
24 This isn't munchable but it is taken

1 both from the Council and the
2 Bureau, your hard work over the
3 years. And really, you know, every
4 chair who gets here doesn't get here
5 from one year's work. They get here
6 from many years of work, and I do
7 really appreciate that, so thank
8 you.
9 DR. FUNK: Any other
10 comments? Well, that being said, do
11 I hear a motion to close?
12 MR. QUINN: Hopefully,
13 for the last time, I move for
14 adjournment.
15 DR. FUNK: And I hear a
16 second. Is there anybody who would
17 not like to approve that? So, all
18 those in favor?
19 SPEAKERS: (Series of
20 ayes.)
21 DR. FUNK: Happy holidays.
22 (Whereupon, the meeting
23 adjourned at 12:10 p.m.)

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1 C E R T I F I C A T E

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4 I, Kyle Alexy, a Shorthand Reporter

5 and Notary Public in and for the State of

6 New York, do hereby certify that the

7 foregoing record taken by me is a true

8 and accurate transcript of the same, to

9 the best of my ability and belief.

10

11

12

13 ______________________

14 Kyle Alexy

15

16 DATE: December 10, 2008