NEW YORK STATE

EMERGENCY MEDICAL SERVICES COUNCIL

(SEMSCO)

June 10, 2009
9:00 a.m. - 12:41 p.m.
Crowne Plaza Hotel
State and Lodge Streets
Albany, New York

APPEARANCES:
Ed Wronski
Donald Faeth
Robert Delagi
Tim Czapranski
Michael Murphy
Andrew LaMarca
Walt Reisner
Richard Brandt
Jack Davidoff, M.D.
Edgar Wedge
Nancy Benedetto
Michael Reid
Paul Cousins
Warren Darby
Storm Treanor
Michael McEvoy
Cheryl Mayer
Raymond Serowik
James Deavers
Vincent Fargone
Lolita Compas
Michael Mastrianni
Colleen Vesely
Mark Zeek
Deborah Funk, M.D.
Daniel Blum
Mark Henry, M.D.

1 MR. FAETH: Good morning, everyone. Thanks
2 for coming. If everyone could put their pagers
3 and cell phones on vibrate, we'd appreciate that.
4 And, Donna, if you'd like to do roll call.
5 (Roll call taken.)
6 MS. JOHNSON: Roll call complete.
7 MR. FAETH: Thank you, Donna.
8 I hope everyone was able to receive the
9 minutes from the February 18th meeting. That
10 should have been sent via e-mail because we're
11 going paperless now.
12 Do we have any corrections? Any amendments?
13 Corrections? Do we have a motion to accept the
14 minutes of the February 18th meeting?
15 MR. LEWIS: So moved.
16 MR. FAETH: Motion made by Al Lewis.
17 Seconded?
18 UNIDENTIFIED SPEAKER: Second.
19 MR. FAETH: Any discussion? All in favor?
20 Against? Abstain? Pass unanimously.
21 Okay. Moving on for business here,
22 correspondences. I did receive a correspondence
23 yesterday, actually, from Dr. Cooper dealing with
24 adopting the national standard for ambulance

1 equipment. I believe we're going to have that --
2 we don't actually have that listing. There was no
3 attachment to that and no listing of equipment. I
4 can see that we're probably going to move that
5 over to SEMAC for review and also probably to
6 Systems, also, so that that can be discussed over
7 the summer and discussed at the September meeting
8 and, hopefully, we can then vote on it at that
9 time.
10 Also, just for purposes of discussion,
11 thought, I guess, later on, I did give everyone a
12 homework assignment to let me know what they felt
13 was wrong with the system and how to improve it.
14 I didn't get a lot of responses back. Some of the
15 topics were recognition for EMS, COM process,
16 looking at universal state protocols, licensure
17 and source testing and whatnot. Obviously, there
18 are other issues. If you have them, send them
19 forward. I'd appreciate it.
20 Chair report. I have several people that have
21 been finally vetted. Congratulations. I believe
22 Jim Deavers is vetted for Debra Fults. Debra,
23 thank you very much, wherever you are. I know
24 she'll continue being active. She's been very

1 active with us. And in light of the fact that
2 Debra was the chair of the Education and Training
3 Committee, we've moved to name Edgar Wedge.
4 Congratulations, Edgar --
5 MR. WEDGE: Thank you.
6 MR. FAETH: -- as the new chair of that
7 committee. We know you'll do a fine job, as was
8 evidenced yesterday.
9 Ray Serowik was vetted for Mike Washington.
10 Mike Reid was vetted for Michael Quinn. Colleen
11 Vesely was vetted for Laura Casey. And Bob Delagi
12 was finally vetted. Cheryl Matrick, I believe,
13 for Dr. Belatier. And I think a few extras I just
14 got, Dr. Davidoff -- Doctor -- was apparently
15 vetted. Warren Darby, congratulations.
16 We have a new member, Lolita Compas, ER nurse
17 for the ER nurse vacancy that we had on this
18 Board. Welcome. I understand you belong to
19 SNYZNA and have a world of experience, and we look
20 forward to hearing from you here.
21 Congratulations.
22 Let me see. Did I miss anybody here?
23 MR. ZEEK: Yes.
24 MR. FAETH: I didn't get yours. You were

1 recently vetted?
2 MR. ZEEK: A couple weeks ago.
3 MR. FAETH: Mark Zeek is vetted.
4 Congratulations. Very good.
5 Also, I don't know if he's here -- is
6 Israel Miranda. Israel Miranda was appointed to
7 fill the non-voting ELS seat on the SEMAC. He is
8 an instructor EMT for FDNY, New York City with
9 many years of experience, and he's also the vice
10 president of the union, and he's also an OSHA
11 instructor, certified health and safety. He has a
12 world of knowledge, also, to be able to assist
13 that committee.
14 MR. MIRANDA: Thank you. Pleasure to meet
15 you.
16
17 MR. FAETH: Also, I have -- I have changed my
18 alternate. I'd like to introduce you to Rene
19 O'Carroll. She will be my new alternate. She is
20 a paramedic in Brooklyn and actively working the
21 streets, and she also has a world of experience.
22 I looking forward to you assisting me. Thank you.
23 Okay.
24 So just so everybody knows, anybody who has

1 not been vetted, just understand that we don't
2 actually have any direct control over that
3 process. That's through the Governor's office.
4 And although we'll continue to request that the
5 process be moved, we don't have any direct ability
6 to move that process. So, you know, we hope that
7 anybody who is still waiting does not have to wait
8 very long and hopefully that will be coming
9 forthwith shortly. All right.
10 I guess the last thing as part of my report is
11 that I just want to thank everyone who attended
12 the EMS Memorial. It was well-attended. We had
13 beautiful weather. It was nice to meet the
14 families, and I felt honored to speak there. And
15 I want to thank everybody who came out and
16 supported the families and supported sacrifices
17 that those two members made. Thank you.
18 Move to the first chair report.
19 MR. DELAGI: No report.
20 MR. FAETH: Second chair report?
21 MR. CZAPRANSKI: No report.
22 MR. FAETH: EMS Staff Report, and Chairperson
23 Wronski.
24 MR. WRONSKI: Thank you. This is our last

1 meeting before the summer, and it was a very busy
2 one. There was a lot done both at SEMAC and in
3 subcommittees, and some things I'm not going to go
4 into until subcommittee reports, and then I'll
5 comment from that perspective on some of the
6 things that have come up at the subcommittees.
7 I do want to reflect again on the EMS
8 Memorial. It was very well attended, and the
9 families were very appreciative of the Memorial
10 and as EMS providers who come to the Memorial are,
11 so thank you for supporting it. We look for your
12 continued support, which I know we can depend on.
13 A number of things. I attended a stroke
14 conference in Westchester County in White Plains
15 recently, and that will be brought up in a couple
16 of different reports. But what I wanted to send a
17 message is that it was very well attended by
18 hospitals who are stroke and non-stroke centers.
19 Of course, there's a great deal of interest in,
20 obviously, the system, which has at this point, I
21 think, 111 or so state-wide hospitals who are
22 designated stroke centers. It affects EMS because
23 EMS is asked that when you identify a stroke
24 patient, bring them firsthand to one of these

1 stroke centers.
2 And what I heard from an EMS standpoint at the
3 committee meeting was a couple of issues that
4 would be useful to improve our education. I've
5 asked Karen to review our curriculum and to see
6 what we can add to it so that our providers,
7 particularly BLS providers, are updated on stroke
8 and how to recognize it and ensure they can
9 understand what the patient is experiencing in
10 front of them and bring them to the appropriate
11 place, because all of the literature -- and that
12 was underlined by a variety of speakers, experts
13 of -- both in this state and nationally on stroke
14 was that the evidence really does show that
15 patients who suffer stroke and can get to an
16 institution that can treat them properly for the
17 stroke, whether that be with TPA or surgery,
18 benefit from it and have better outcomes, so EMS
19 plays a critical role in that.
20 What came out clear was that patients often
21 don't know they're having a stroke, and,
22 therefore, there's delays. When they do call EMS,
23 you may be the first person who can determine
24 whether or not they may be having a stroke. And

1 if that call was made to you early enough, you can
2 make a very big difference in their outcomes down
3 the road if you bring them to the right
4 institution. And so, again, it was underlined and
5 underlined how critical EMS's role is in the
6 provision of stroke care to patients. And so
7 we'll look at our education and see if we can
8 assure that that's sufficient to make sure that
9 EMS does this.
10 One particular issue that was brought up by
11 some hospitals was that they were experiencing in
12 some cases a late call by EMS to notify the
13 hospital that they are bringing in a patient who
14 they believe is suffering a stroke. And what they
15 meant by "late call" is EMS might get them on the
16 radio a few minutes before they arrived at the
17 hospital, and they were requesting that EMS call
18 as early as possible. So as early as your crews
19 know or believe they know that someone is
20 experiencing a stroke, they should call the
21 hospital they're going to and say, "listen, we
22 think this is what's going on. Please alert your
23 stroke team and have them prepared." So that's a
24 critical factor. And we're certainly going to do

1 what we can from the Department's end to send that
2 message out. I ask you to do that at your
3 regional level to improve the care to the stroke
4 patient.
5 One of the major things that happened over
6 the -- in the interim from the last meeting to
7 this one was we have reconvened the Test
8 Preparedness Committee, which is going to meet
9 this afternoon for a few hours just to go over
10 issues and recommendations they made. Bob
11 Burhans, who is the director, has asked the
12 Preparedness Department, who will be there, to
13 give an update to the committee, and there will be
14 some general discussions. This was all decided
15 months ago to do this.
16 But what happened over the last few months was
17 something that tested our system, because we had
18 the swine flu. Now, as everyone knows, the
19 reality of the swine flu is that this particular
20 version of it has not been more concerning than
21 ordinary flu, but it was definitely more
22 concerning to the public because it was new, it
23 was misunderstood; and when that occurs, you get a
24 lot of worried well. And while we've had some

1 worried well visit our hospitals in all parts of
2 the state, really, where it was a big impact was
3 New York City. And Nancy Benedetto from New York
4 City is shaking her head because she knows very
5 well what has gone on in the city and continues to
6 some extent to go on today to the point where some
7 hospitals in the city actually set up tents
8 outside of the emergency departments to screen
9 patients who were coming in with flu symptoms, and
10 to try to lessen the load on the emergency
11 departments, which was becoming increasingly a
12 burden and affecting the EMS system.
13 And we were in daily contact with FDNY and the
14 city officials during this time, and I appreciate
15 the regional council's work with the city in this
16 whole effort to assure that there was, in fact,
17 mutual aid within the city and the system. And if
18 you don't know, it's rare that FDNY EMS calls for
19 mutual aid within their own system. It's very
20 rare. They have done so a handful of times
21 already during this particular event to bring in
22 players to the system that are not normally
23 responding to EMS from -- through the 911 system,
24 through the FDNY 911 system. They were asked to

1 come in and assist because their system was so
2 overloaded. And that gives you a sense of what an
3 impact this was.
4 And to give you a real sense in pure numbers,
5 their daily 911 call volume rose from what had
6 been a growing average from a few years ago of
7 3,000 a day to about 3400, so that they, with this
8 event -- and they were now reaching in many days
9 more than 4,000 911 calls a day. Most services in
10 the state don't do 4,000 in a year. The city was
11 doing 4,000 a day. And that was absolutely
12 incredible.
13 So, you know, I congratulate the city, FDNY,
14 the regional council, for managing to address this
15 locally, but it is a continued stress, and we need
16 to learn from this for future disasters because a
17 big, big impact is, in fact, getting the right
18 message to the public about what is going on and
19 try to limit the effect that the public has on
20 your day-to-day healthcare system. And it's a
21 problem, and it's a problem that's not yet been
22 solved either in New York or other states, but
23 it's one that, you know, shows its head when we
24 have one of these emergencies, and we have to

1 learn by this. We'll have more discussions
2 regarding the swine flu and hand flu and other
3 things this afternoon.
4 One last item, and I'd like to put this on the
5 record, is that we did learn that many agencies do
6 not stock N95s. The recommended mask for swine
7 flu and in the past for other types of diseases
8 has been the N95 mask. And it also requires fit
9 testing. We did learn that many agencies simply
10 don't have stocks, even temporary stocks. And my
11 recommendation to EMS services across the state is
12 that they maintain at least a small stock in-house
13 of N95s. And while you're not going to be
14 expected to have a stock of N95s that's going to
15 last, maybe, the course of, say, an epidemic, it
16 would be prudent for you to be able to have
17 fit-tested staff N95s and have a small stock of
18 N95s always available in case an emergency occurs,
19 until such time as your local system, if need be,
20 can get you additional stocks or you can order
21 additional stocks. But that was an issue and
22 remains a concern. We are developing in-house an
23 updated training program for fit-testing for N95s.
24 And, actually, we have already signed off on a

1 final program there. It hasn't been finally
2 signed off on by public health, but it should be
3 soon. We intend to share that with all the
4 regions in EMS, and it may be a useful document
5 for some of you to give you a tool for
6 accomplishing fit testing in the regions.
7 Okay. A couple of other things. The
8 State Trauma Advisory Committee met, one item that
9 you should know, and Dr. Henry may cover this a
10 little bit in his SEMAC report, but it was a full
11 meeting. It was also a very telling meeting,
12 because we had two reports given to us at the STAC
13 meeting regarding the accomplishments of the state
14 trauma system in our state.
15 You're part of that system. And when we do an
16 evaluation of how the trauma system works, it
17 includes EMS. The outcomes of patients are
18 important, not just to what hospital they go to,
19 but the fact that you're available and can
20 identify them and know to bring them to a trauma
21 center and provide them care in a hospital arena.
22 But the reports that we're seeing and that we
23 saw at the last State Trauma Advisory Committee,
24 based on the data that we've collected for three

1 years going from 2003 to 2006, demonstrate that
2 the New York state trauma system has improved each
3 year in its risk-adjusted mortality rates for
4 patients and has improved the care to New York
5 State citizens. We also looked at CDC data, and
6 the School of Public Health ran the New York State
7 data using the CDC algorithms as well to compare
8 us with CDC outcome data for the country, and New
9 York State does remarkably better as a state
10 system than the nation does. And I think that's a
11 credit to you. And this isn't forgetting that a
12 lot of what we could in the state, also, is
13 underline seat belts, helmets, safety, et cetera.
14 But part of it is the direct care you give to the
15 patients who do suffer traumatic injuries in the
16 trauma centers and what care EMS can bring to
17 bear. But the report is definitely showing that
18 care is improving in the state, continues to
19 improve, and we do better than the country as a
20 whole, so congratulations to you in your role in
21 that.
22 I'd like to make an announcement. As all
23 of you know, I have no deputy or assistant
24 director, and there's a lot of work to do in the

1 Bureau, much of which sits on my table, although I
2 try to move it along as quickly as I can. And
3 I've been reassigning staff in different times to
4 take some of that work so that it moves along
5 quicker. I have been given permission to appoint
6 an acting deputy director, and that is Lee Burns.
7 So Lee Burns will be the acting deputy director
8 for the Bureau. I do not know long term about the
9 fill for the position formally. That will come in
10 time. But for now and probably for a while, Lee
11 Burns will be the acting deputy for the Bureau.
12 So when I'm not around, Lee will be in charge of
13 the Bureau, and she's done that in the past, as
14 some of my other staff have. You know her, and I
15 think you can work with her and she can work with
16 you, so I wanted to let you know that formally.
17 If I'm not around, you can speak to Lee.
18 Office-Based Surgery -- I mentioned this at
19 the SEMAC -- the statute for Office-Based Surgery
20 in the regulations kick in -- have kicked in, but
21 the reporting becomes more important as of July
22 14. As of July 14 any office-based surgery center
23 that uses moderate anesthesia for its patients in
24 surgery must have applied for and been approved as

1 a surgery center, approved by the Department for
2 Office-Based Surgery. After that date surgeons
3 and physicians who participate in surgery of
4 patients at an office-based surgery center who are
5 not approved, the surgery center is not approved
6 to do this and they use moderate anesthesia will
7 be referred to the Office of Professional Conduct
8 for disciplinary action.
9 This is also important for the SEMAC members
10 to know, and I did advise them because hospitals
11 are required to report adverse outcomes. Now,
12 hospitals may not know which surgery center has
13 been approved by the department or not, and it's
14 not your job to investigate that. But if you have
15 an adverse outcome that has been identified at the
16 hospital, the hospital is required to report that.
17 I'm advising you because you're part of the
18 system; you pick up patients all the time, and you
19 should be aware of it.
20 You are not included in the requirement for
21 reporting in this law, but the hospitals are. So
22 what's your role? Frankly, your role is if you
23 have concerns, you can certainly speak to the ED
24 staff, if you think you have concerns on a patient

1 that you've picked up somewhere. And then -- but
2 then it's up to the hospital to evaluate whether
3 or not this is a reportable incident or not.
4 I think the remaining items that I have on
5 my list are all going to be covered except for
6 one. I did -- I will thank Dr. Funk for staying
7 with us. She reminds me of things that sit on my
8 desk. And -- I have to do that -- the -- I
9 promised a letter; I didn't write it, and I will
10 write it. I have gotten a commitment of the
11 Director of Hospital Services, and I did meet with
12 Haney's representative probably two months ago,
13 and they agreed to support -- in concept, they
14 would like to see the letter in a draft but they
15 support the letter -- but it would be a letter
16 going out by me and Hospital Services to all
17 hospitals in the state asking they support
18 training efforts within their hospital confines.
19 A lot of you have brought to our attention that
20 some hospitals are becoming less and less likely
21 to open their doors to core sponsors who have had
22 traditional agreements with them to have training
23 on-site at the hospital. And that would be a real
24 damage to the system if hospitals did not allow

1 that to occur, so we'll send a letter out
2 indicating that as long as they have agreements
3 with an approved core sponsor in the state, this
4 is entirely legal to do, and we encourage them to
5 do so. And that will come out from both me and
6 Hospital Services, and we will run the letter by
7 Haney's first so that we know the hospital
8 association is supportive of the language and they
9 can tell the members that. But again, thank you
10 to the former chair, Dr. Funk, for reminding me of
11 that.
12 DR. FUNK: My pleasure.
13 MR. WRONSKI: Are there any questions?
14 MR. FAETH: Next on the agenda we have state
15 EMS advisory report, Dr. Henry.
16 DR. HENRY: I would say, as Mr. Wronski did,
17 that the main topic since our last meeting was the
18 H1N1 virus. And I think it's very important for
19 all regions to review their plans for pandemic flu
20 and to get that information disseminated as much
21 as you can. Because the nature of these viruses
22 is that they can change in how severe the impact
23 can be, and they can -- since they're contagious,
24 they can affect EMTs and paramedics and nurses and

1 doctors and anyone along the line, registration
2 people who are exposed to them. There are
3 medications available if you're exposed and you're
4 not protected.
5 There's ways to protect yourself. You can't
6 let your guard down on this. Otherwise, bad
7 things can happen. As we know from SARS, people,
8 including paramedics, got sick in Canada, and some
9 of them died. While this H1N1 doesn't seem so
10 lethal at this point in time, things can change.
11 So this is -- it's really happening.
12 And I think what happened in New York over a
13 day or two, there was a spike in the number of
14 people calling in with respiratory symptoms.
15 That's the nature of these diseases. If we --
16 that's why we prepare for the bio events, because
17 they sort of lay dormant, and all of a sudden you
18 can see a big spike in the number of people who
19 have need, and you have to know what the plan is.
20 So I think it's important that everyone stay
21 alert.
22 Where do you get your news for this? I've
23 been on the Internet each day, because that's
24 where your reports come back, you know. A lot of

1 it, as you know, changes as testing becomes
2 available in terms of how many are "confirmed."
3 If you don't have the test to set up to do
4 confirming, you don't confirm them, but you
5 suspect they're there. The more testing becomes
6 available and samples are sent in, then you might
7 see more "confirmed" cases.
8 But at our level you have to be aware that has
9 to do with what supplies are available and what
10 facilities are available for testing. And that's
11 also true for what supplies come from stockpiles
12 for medications, such as Tamiflu or Alenza or
13 other agents, so it's very important to stay alert
14 on that.
15 MR. KAUFMAN: Dr. Henry, can I make a few
16 comments on the flu as well?
17 DR. HENRY: Please.
18 MR. KAUFMAN: Brad Kaufman from the Fire
19 Department in New York -- New York City.
20 Obviously, we were hit very hard by the
21 numbers of increases for ambulance responses
22 initially, and then there was a lull, and then
23 again over the past week or two to the point where
24 our providers were under a lot of strain, being

1 mandated to overtime as well as requests for
2 mutual aid on a number of days. The numbers have
3 gone down slightly. They're still above the
4 levels that we would anticipate. But we expect
5 the numbers for flu will go up again either in the
6 fall or in future waves. We also are concerned
7 about the numbers that normally go up in the
8 summertime during heat waves.
9 We've obviously been meeting every day, doing
10 a lot of measures to try to deal with these large
11 numbers. First of all, protecting the providers,
12 so as you mentioned, we've had very aggressive PP
13 requirements for the providers in a number of
14 ways. First of all, we have changed our 911 call
15 screening questions to add questions to help
16 identify those patients who may be presenting with
17 symptoms consistent with the flu. So now our
18 call-receiving operators are asking about fever,
19 cough, runny nose, sore throat, et cetera, for
20 certain complaints. And if the caller reports
21 that those symptoms are present, those calls are
22 flagged, so the provider, the EMTs and medics,
23 will know to don PP even before approaching the
24 patient. If the call should go out as another

1 call type, the crew, after approaching the patient
2 and identifying any of these symptoms, will
3 immediately don PP for those patients.
4 Similarly, once the crew transports the
5 patient to the hospital, we're requiring them to
6 give notification to the hospital so they know
7 exactly where to bring the patient within the
8 hospital. Many of the hospitals in New York City
9 have set up alternative areas for triage and
10 quickly passing these patients into a separate
11 area to keep them away from the general emergency
12 department population.
13 We found that the large increase in calls --
14 that many of these callers are often seeking
15 information about the flu, not sure what the
16 appropriate step is. They think they may need to
17 be transported to the hospital to be evaluated,
18 but are really seeking information but have called
19 911. In the past we would send an ambulance and,
20 of course, recommend transportation and then have
21 a mechanism to provide them with the information
22 that they were really seeking when they called
23 911.
24 As of today, as a matter of fact, we've

1 started a new process whereby selected
2 low-priority 911 calls who are secondarily
3 identified as these special flu-type calls, the
4 caller is given the option of do they want an
5 ambulance response or are they solely seeking
6 information about the flu. If they are solely
7 seeking information about the flu, we have the
8 ability to transfer them to what we're calling a
9 flu information phone provider, who is also
10 staffed by EMTs or paramedics from the fire
11 department. Our first day of going live will be
12 this morning, as a matter of fact, and we'll see
13 how many calls get transferred to this mechanism,
14 as we'll see with alternative destinations. We're
15 not sure. Many of these callers may, indeed, want
16 an ambulance and want transport to the hospital
17 and, of course, we're not denying anybody
18 transport to the hospital. But if they do not
19 want the ambulance and are solely seeking
20 information, we'll be able to provide them with
21 that information, not only by speaking to a
22 provider but also sending them e-mailed
23 information or faxed information, so I think we'll
24 be following these as the days go on and see how

1 successful all these plans are.
2 DR. HENRY: Thank you. You know, that reminds
3 me that I just heard a report from the president
4 of the European Association of Emergency Medicine.
5 He's from the Karolinski Institute in Sweden. And
6 he was talking along the point you just mentioned,
7 that lots of people who come to emergency
8 departments in Europe, like here, are seeking
9 answers to questions. 80 percent of the patients
10 who come to emergency departments go home.
11 They're not admitted to hospitals. But they have
12 a question, is this pain serious? Should I be
13 concerned about my child who has fever and sore
14 throat? Or, as you're mentioning here with the
15 flu, what should I do? Schools are closing, what
16 should I do?
17 So they set up an information system there,
18 too, where people could go through the Internet
19 and it was available to answer their questions.
20 They cut the visits appreciably, people coming to
21 the department because they were seeking answers
22 to questions. And I think what you're doing is
23 answering the need without dispatching a vehicle
24 and making a transport, and I'm eager to hear the

1 results of that.
2 Associated with this, then, is the question
3 should patients with a contagious illness be
4 brought to a hospital and mixed with people who
5 are very ill in close proximity who are waiting to
6 be admitted to hospitals but are laying in
7 emergency departments because they aren't up there
8 yet, and I'm concerned about that. I notice, if
9 you look at some of the New York State directives
10 on this, they're discouraging patients from going
11 to emergency rooms. They're saying go to your
12 doctor, because that's not, I don't think, what we
13 would want as a system to do, to mix people with a
14 contagious illness with those who already have
15 comorbid conditions who would be most susceptible
16 if they got an influenza on top of their already
17 COPD, diabetes, et cetera, renal failure, which
18 would impact their mortality. So we have to think
19 as a system, is this a logical thing to do or not.
20 And like this notification in advance, that's very
21 important that we work together.
22 So along those lines, we note that Nassau
23 County, when they introduced their protocols
24 today, had a section on diversion and redirection.

1 That gives some sense of the status of emergency
2 departments in Nassau, if there's a need for such
3 protocols. Where the hospital goes on the
4 diversion, because they claim they can't manage
5 any further emergencies and all their beds are
6 filled, and there's three ambulances waiting more
7 than 30 minutes to be triaged already there. So
8 is that the place where we want to bring people
9 who have the flu?
10 So we have to think as a system, does this
11 make sense or not, or are we adding to a problem.
12 So there are notifications that go out to the
13 public discouraging people to come in. I think
14 911 centers have a role. If people are calling
15 for information on this because the schools are
16 closed nearby and now someone in their family has
17 fever and a cough or sore throat or other
18 respiratory illnesses -- they meet the definition
19 -- and they have questions, where should they be
20 directed to go? So I think it's very important.
21 We're going to talk about that more this
22 afternoon, which, as Dr. Kaufman said, it's
23 important to think about locally and work together
24 with the hospitals, what makes sense.

1 As Mr. Wronski also said, we should take some
2 pride in the fact that working together we've made
3 an impact on survival for trauma patients in our
4 state, and I'm going to ask Dr. Vessi from New
5 York Presbyterian and Dr. Hannon from the State of
6 Public Health, who gave these reports at the STAC,
7 to come to our next meeting, if their schedules
8 permit, and share those reports with you, because
9 we should see collectively what we can do, and
10 it's a significant impact. It's like a 20 percent
11 reduction in mortality. So that's something
12 that's significant that we've all done together.
13
14 The last note I want to make now -- and I'll
15 make other comments during the Medical Standards
16 report with Dr. Marshall -- is there is an EMS
17 medical director course that's going to be given
18 July 8 and 9, New York State, by experienced
19 medical directors from Monroe County region, from
20 the Albany region, from New York City, so the
21 geography of the state is covered. They have
22 experience as agency directors and air medical
23 with REMACs, you know, multiple roles, so I would
24 make this information known in your regions and

1 urge your own people to come and take advantage of
2 this course, which couldn't be better aimed at our
3 own people, and taught by some of our most
4 experienced providers. So I hope there's more of
5 these outside. There were yesterday; we
6 distributed them. But July 8th and 9th is the
7 ACEP course, New York ACEP course, and it's at The
8 Sagamore, so maybe Dr. Funk or others can speak
9 about it, too.
10 DR. FUNK: We can cover it.
11 DR. HENRY: But it's what we want to do. This
12 is power. When you bring people from different
13 regions together and you get to contemplate and
14 spend two days together talking about common
15 problems and common objectives, that's a very
16 powerful meeting. So not only will it be to
17 benefit them, but it will benefit all of us to
18 have people from all over the state come. So if
19 the agencies have -- could reach out, I think that
20 would be a good thing to do.
21 DR. FUNK: I do have one extra copy of the
22 information here. The program is held in
23 association with the New York ACEP summer
24 conference, which is at The Sagamore. It's a

1 lovely conference and a great environment. If you
2 don't have a copy and you're interested in it, go
3 to the website, which is www.nyacep.org -- it's
4 nyacep.org, and you can get information and
5 registration forms for the program.
6 MR. FAETH: Thank you, Deb.
7 Any questions for Dr. Henry? Thank you,
8 Dr. Henry.
9 Before we move our agenda to the committee
10 reports, we have a presentation from our second
11 vice chair, Tim Czapranski, on the alternative
12 destinations.
13 MR. CZAPRANSKI: Thank you.
14 So it was about a year and a half ago when I
15 came before SEMAC and then this body requesting an
16 approval of an alternative destination project in
17 Monroe County, so I have a brief slide show
18 presentation. I'd kind of ask everyone to hold
19 their questions until the end, and we'll go
20 through that now.
21 So sort of as a brief review, the 911 system,
22 especially in the urban community, in Monroe
23 County and the City of Rochester, is used as
24 primary care. People call 911 when they have an

1 issue. They go to the hospital ED. They get
2 treated, and then they go home. And the next time
3 it occurs, they call 911. And that results in
4 very little continuity of care and little in the
5 way of follow-up. Despite the discharge diagnosis
6 and the instructions, the patients don't
7 necessarily follow through, and no one follows up
8 with them. It's a poor substitute for primary
9 care, and it's also very expensive when you
10 consider the EMS transport costs and the ED visit
11 costs for, typically, low acuity issues.
12 For decades we've taught people to call 911,
13 and we've been very successful at getting that
14 message out there. It continues to increase. In
15 our county it increases 8 percent a year. And the
16 majority of that increase for 911 EMS calls is for
17 the priority 4, low acuity patients.
18 So we decided to move forward with an
19 alternative destination project. And in our
20 community there's a community access management
21 committee that includes hospital CEOs, the County
22 Department of Health, New York State Department of
23 Health, insurance companies, the medical society,
24 and they sort of said, "Yeah, this is a worthwhile

1 idea. Let's try to move this project forward."
2 So it was a collaborative from all the
3 stakeholders.
4 In Rochester, rather than have a paramedic go
5 on all 911 calls and try to make a decision based
6 on triaging, we chose to use a subset of calls
7 that we deem to be very safe. So we began with
8 911 calls that go through the call center protocol
9 and drop down into a bucket that says "priority 4,
10 low acuity," and, in fact, those calls don't even
11 get a lights-and-sirens response; they get a cold
12 response. And then we reached out and got grant
13 funding for a trial, which, really, the biggest
14 expense for grant funding was the medical control
15 piece.
16 Some of the data that led to this, you can see
17 what our ambulance drop times are when we measure
18 them. The top line is the ALS drop times in
19 hospitals, and the bottom line is the BLS drop
20 times in hospitals. And it continues to climb a
21 little bit. And that's a concern. In our
22 hospital systems, as this slide shows, we
23 typically have more patients than we have staff
24 beds. Our hospitals typically run up 108 percent

1 occupancy. So, consequently, that backs up into
2 the ED and it backs up into the triage line.
3 And, you know, today -- this morning at 7:30
4 all our hospitals were code red on diversion. All
5 of them had ambulance stacking times waiting more
6 than two hours, so that backs up into the 911
7 system, and it inhibits our ability to respond to
8 the community. So what if we took some of these
9 patients out and took them to a clinic?
10 Well, the alternative destination for
11 qualifying 911 calls -- and these are the project
12 parameters -- must be blind to the ability of the
13 patient to pay. We weren't going to have our
14 paramedics on the street trying to determine if
15 these patients qualify by their insurance carrier.
16 The drop times at participating facilities had to
17 be less than or equal to ten minutes, so we need
18 to get that ambulance back in service quickly. So
19 the triage at those places had to cut our EMS crew
20 loose quickly. And as you can see from our
21 average drop times at hospitals, going from 40
22 minutes to 10 minutes would effectively put more
23 unit hours on the street.
24 Every call gets online medical control. Every

1 transport gets a physician quality assurance
2 review. And this was, again, if you remember, a
3 paramedic-only protocol, not just for the
4 assessment side but also for the transport.
5 We partnered with the Finger Lakes Health
6 System Association for purposes of continuity.
7 They run safety net projects and others. And
8 while this was a good working relationship, on
9 several occasions the project was handed off to a
10 different project manager at the Finger Lakes
11 Health System Association, which did not
12 necessarily help the project in the management
13 process because they were the primary managers of
14 it.
15 We partnered with Primary EMS Agency in
16 Rochester, and our timing, we thought, was perfect
17 because we were going to begin this project when
18 the new city contract began, the City of Rochester
19 contract for EMS service, but it didn't work out
20 that way. The City contract got a little bit
21 contentious on EMS between two agencies and
22 between City Council and the mayor, and so it got
23 kicked back and forth. And the focus of the
24 Primary EMS Agency was on gaining a contract and

1 continuing to do service as opposed to taking on
2 new projects, and that was certainly an issue for
3 us. Timing couldn't have been worse, as it turned
4 out.
5 One of the other parameters was the patient is
6 seen by a practitioner at these clinics in less
7 than 60 minutes and that there's appropriate
8 medical follow-up. If the discharge notes say
9 "follow up with physician 'XYZ'" or had a
10 prescription, someone would call and make sure the
11 prescription was filled and the patient was seen
12 according to the follow-up requirements.
13 Some of the lessons learned, it's incredibly
14 complex and it relies on healthcare system
15 partnerships. We had insurance companies that
16 compete against each other in the same room
17 dealing with reimbursement issues for urgent care
18 versus clinic settings, and so we ended up with a
19 lot of issues that we had to focus on and agreed
20 to put aside for the benefit of this project.
21 It was a safe protocol. It was an extremely
22 safe protocol. There were no untoward outcomes
23 from this, as a result. It had extremely low
24 utilization, and we'll get into that a little bit

1 later.
2 And the reimbursement issues, you know, we can
3 talk a little bit about that. But the clinic
4 versus urgent care are two levels of
5 reimbursement, the clinic being the lower level of
6 reimbursement, urgent care being the higher level
7 of reimbursement. Some of these clinics were not
8 necessarily interested in taking patients without
9 insurance because they already are not-for-profits
10 and they're already running a little bit into the
11 red, and they didn't want to increase that. As
12 they quoted to me, "No margin, no mission." So the
13 insurance companies got together and said, "Well,
14 we can raise your rate to an urgent care rate,
15 which is a higher rate for all your patients, if
16 you meet certain criteria," and we were successful
17 in doing that, which basically gave them the
18 necessary revenue to cover those patients who were
19 uninsured.
20 There was community resistance to change. One
21 of the things that we found is typically, when
22 someone calls 911, they have a certain
23 expectation, and when you try to interrupt that
24 expectation, there's a degree of resistance that

1 we hadn't anticipated.
2 The medics were reluctant -- and this goes
3 specifically to the paramedics -- for a lot of
4 reasons, and we'll talk a little bit more about
5 that later. But it suffices to say that you need
6 the paramedics on the street. You need their
7 support in this project to make it successful.
8 The clinics were not willing to take no pay or
9 Medicaid. So here's an interesting one, suburban
10 versus urban. Inner city clinics agreed to sign
11 on meeting all the criteria for being part of this
12 project. The suburban clinics said they were not
13 interested. "We don't want Medicare; we don't
14 want Medicaid; and we don't want no pay, so we're
15 not going to qualify for this project."
16 In the suburban areas the EMS agency says,
17 "We've got patients perfectly willing to go to
18 clinics, but they want to go to the clinics in
19 their neighborhood; they don't want to go to the
20 inner city clinics, 15, 20 miles away."
21 So it was a little bit of an issue where we
22 had a population in the suburban wanting to trial
23 it but not wanting to go into the city far away
24 from where their home was.

1 Many of the inner city clinics were challenged
2 with staffing. They wanted to participate but
3 they could not due to shortages. So initially
4 they signed on and we started looking at it, and
5 they sort of backed out and said, "Well, you know,
6 we really can't take any more additional
7 patients."
8 The EMS contract disruption -- the contract
9 with the City of Rochester is in litigation still,
10 and that did not play in favor of this project.
11 So some of the challenges were the
12 paramedics were working harder and seeing more
13 patients, and that was really not looked at as an
14 incentive from the paramedics. You know,
15 typically, if I'm a paramedic, I do my ALS calls
16 and, according to Medicare regulations, I do some
17 of the other calls and ride them in, and when that
18 BLS priority 4 call non-lights-and-sirens comes
19 in, my EMT partner climbs in the back with the
20 patient; I drive. I get to the hospital. I get
21 my 30 minutes of downtime, and, you know, it sort
22 of builds me up for my next ALS call.
23 Now we're suggesting that no, you don't get
24 that downtime. You get to take and assess that

1 patient, and your partner can't ride with you.
2 You need to ride in the back of the ambulance and
3 go to a clinic. And you don't get that 40 minutes
4 downtime because the clinic is going to release
5 you in less than 10 minutes so you can go back to
6 another call.
7 So the paramedics really didn't see this as an
8 incentive, you know. "I get to see more patients.
9 I get to work harder, and for what reason?" And
10 so that was certainly a concern that added to the
11 dissatisfaction of this project.
12 EMS was moving to a tiered response in the
13 City of Rochester where, sort of, when we began
14 the idea of this project, all the ambulances were
15 ALS. It moved to a tiered response system with
16 BLS ambulances and ALS flag cars. So instead of
17 sending one ambulance to a call and having the
18 paramedic do the assessment and offer the
19 opportunity of a clinic setting to appropriate
20 patients, we now had to send the BLS ambulance
21 plus an ALS flag car, so resource utilization was
22 an issue, and that didn't work out very well for
23 us, either.
24 And the patients wanted the ED. As I said

1 earlier, the expectations exist. "I want to go to
2 the Strong. I always go to Strong Hospital, so
3 take me to Strong Hospital."
4 We also found it difficult to get really good,
5 accurate feedback from reluctant medics. They
6 didn't want to say they didn't want to work
7 harder, but they were clearly not interested in
8 pursuing this project. Many of them didn't even
9 endorse the idea of rolling it out to their
10 patients. They get on the scene and say, "This is
11 my priority 4. This is my partner's call. And
12 since he can't roll it out to the patient, I'm not
13 going to bother, either."
14 Some the issues we have -- and, you know, sort
15 of this is where I beat my head against the
16 wall -- and I found myself going home and ranting
17 at dinnertime around the dinner table with my
18 family about this project that my wife decided to
19 nickname the project, "This is your Apollo 13."
20 Because here we have a patient who does all the
21 right things. She calls at 10:05 in the morning;
22 she calls the clinic and gets the message,
23 "There's no standing appointments if you're
24 calling after 9:30 a.m., so you need to call 911."

1 So she calls 911 to go to the emergency
2 department.
3 The paramedic gets on the scene and says, "We
4 can take you to that clinic because they're a
5 participant in the project."
6 And she says, "Oh, no, I just called them.
7 They won't see me today."
8 So the only way this patient would qualify was
9 if she called 911 and went by ambulance to the
10 clinic, which is sort of the opposite of what we
11 were trying to do. She wouldn't qualify if she
12 called the clinic and went there by taxi or by
13 privately-owned vehicle. So some of those issues
14 were sort of a challenge.
15 So from here -- I'll get into the numbers a
16 little bit later -- but in Rochester area we have
17 the 20/20 commission targets, which have just come
18 out last week. And the 20/20 commission is made
19 up of a lot of folks in the healthcare system, and
20 sort of their targets in looking at EMS and the
21 911 center to help with some of these projects, so
22 these of some of their charges.
23 The work group on suboptimal ED use will
24 investigate ways to reduce the number of low

1 acuity ED visits to Monroe County hospitals, and
2 then it lists among the work. So, you know, if
3 we're going to decrease those low acuity by 15
4 percent, everyone sort of looked at EMS and 911
5 and said, "Wow, this is the way you guys can help
6 us do this."
7 Other things they've been doing is by November
8 of 2009 was to look at implementing locally
9 reduced ED visits and identify the stakeholder
10 groups involved, and, again, so far the only
11 stakeholder groups involved that they've
12 identified are 911 and EMS.
13 The next bullet talks about the commission's
14 preliminary goal, to decrease by 25 percent the
15 number of ASC patients, and those are really
16 described as patients who come into the ED and get
17 admitted to the hospital, but had they had proper
18 primary care, they would not have required an
19 admission and maybe not even an ED visit. So what
20 do we do to get them into the proper primary care
21 so we avoid the whole circumstance? In our
22 community in a two-month period, patients who are
23 going to the ED, get admitted to the hospital, get
24 discharged, and then come back for a readmission

1 within two months, over 80 percent of those
2 patients did not follow their discharge
3 directions. They did not do a follow-up visit
4 with their practitioner or anything else. So
5 there are lots of ways that we need to do this,
6 but it's a significant issue.
7 Now to the numbers, and this is a 12-month
8 aggregate. For priority 4 calls there were
9 13,000, almost 13,500 priority 4 cold response
10 calls. We took out the almost 4,000 psych calls
11 because they didn't qualify. And then we had 1200
12 of them fall outside the protocol due to age and
13 vital signs. 463 were taken out because they were
14 either referred to the ED by an MD, which we
15 decided, even though they met the protocol, not to
16 mess with them because physicians can get a little
17 ticked off if you redirect their patient, or they
18 were pregnant or postoperative. A thousand calls
19 were taken by non-trained paramedics, and 2,600
20 calls were taken by non-paramedic, and that's
21 growing again; those are the BLS ambulances going
22 to the scene but no ALS flag cars available to
23 come do this BLS transport.
24 So there were a little over 4,000 remaining,

1 and out of that there were 21 transports, the
2 majority by one paramedic. So this ended in
3 December, I think December 4, so in June there was
4 only one patient; July there were none, and August
5 there was the last patient, one patient was
6 transported. And this is really our high-priority
7 four months, so it really was sort of a dying
8 project without the support of the EMS agency and
9 the medics. And the project ended in December
10 because there was no more money for the medical
11 control.
12 Interest remains high in the EMS agency in our
13 community along with partnership with the local
14 state assemblyman. We looked at Philadelphia,
15 Houston, Richmond, Seattle, all with nurse triage
16 versus EMS. These places have put nurses in the
17 911 centers and diverted patients, so there's not
18 even an EMS response for some of these types of
19 calls, and that may be worth looking at.
20 And, you know, the final question is were we
21 too stringent? Did we create a process destined
22 in by limitations to fall short of where our
23 expectations were? And the one clear thing that
24 really resounded out of this was EMS's healthcare

in putting together the medical society and the insurance companies, the hospital CEOs, the clinic CEOs and the physicians really sort of -- we operated public safety on 911 calls, but we really are the beginning point for a healthcare event, and we really have to be involved in that going forward.

I wanted to say thank you to this body but also to SEMAC and certainly to the Bureau of EMS, to Dr. Henry, Dr. Funk and Ed Wronski for supporting this project. While it did not achieve our desired goal, it was an effort that we enjoyed doing, and we certainly learned a lot. The community learned a lot. I think the community of healthcare related to it, everybody from insurance companies, ED directors, clinics. So, you know, we succeeded in completing the project and finding out there were a lot of other issues that need to be addressed. So I'll open it up to any questions now.

MR. FAETH: Thank you.

MR. LEWIS: Tim, was there any education to the community regarding this going on so that people would know that our -- seeking primary care

through 911 that they may not be taken to a hospital.

MR. CZAPRANSKI: We had a committee look at that. There was education for the medics, and then there was a bilingual pamphlet that went out with the medics to sort of give to potential patients. We talked about rolling out, sort of, some type of public campaign, but decided that we didn't want people increasing their calls to 911 with the expectation they would be transported to their doctor's office or to a clinic. So when we trialed it, sort of, that was the feedback was no matter how we twisted the message, it seemed to be okay, you can call 911 now and get transported, if transport is your issue. And it looked like it was going to increase the call volume as opposed to decrease it, so as a collaborative, the group decided not to do that.

MR. LEWIS: Any thoughts on how to get EMS to buy into this going forward?

MR. CZAPRANSKI: I think the protocol was too stiff. I think when you're asking paramedics to do more, when you're trying to reassign basic workload, I think it certainly is a concern or an

issue. You know, we had medic control on every call with a dedicated physician, so what's to say -- I mean, these are already a subset of very healthy patients with minor issues to fall into the bucket of cold response priority 4. So can this be done by an EMT at the basic level with medic control, a physician or somehow a process to follow, so I think there are ways to change the protocol.

I do think it was too stringent. We heard that clearly. If I do the assessment and my partner can ride with the patient, that's better, or what's wrong with letting a BLS ambulance do this? We're sending a BLS ambulance on the call in the first place. You have to contact med control and med control clears them to go to the clinic. They're still being seen by a practitioner, in many cases in our community sooner than they are when they go to a hospital.

So I think the protocol was too stringent. You know, we didn't anticipate all these issues when we walked into it, but we certainly found them, and it does point to a less stringent protocol.

MR. LEWIS: We certainly embrace that and endorse it and have talked about it with DOH on several occasions, and I believe there's a lot of money to be saved in healthcare if we can just figure a way to make this work. I'm hoping that somebody will -- or maybe you would pilot again with what we've learned as a backdrop and maybe make it happen.

MR. CZAPRANSKI: Yeah, I think you're right. There is a lot of money to be saved on the aggregate. It's also going to improve the quality of life. If people get in to see regular practitioners, they won't have the episodic episodes -- episodic episodes, that's a good one. And I think it also improves the continuity of care. This is a win/win/win, but it certainly is frustrating trying to get through all the issues. And I'm not sure I want to try it again.

MR. FAETH: Thank you.

MR. ZEEK: Tim, I think it's very helpful what you've done and very revealing for an idea that on the surface seems like a no-brainer. Once you get into it and you find out how complex it is and how it will work or won't work, and just by getting

1 the groups together to work together that you did,
2 that's a huge accomplishment.
3 MR. CZAPRANSKI: Yeah.
4 DR. HENRY: I commend you, too, and I think
5 there's a lot that's been learned from this, and I
6 hope you write it up and publish it, and I hope we
7 talk about it more. Some of it is sort of
8 paradoxical. You're guarantying people they're
9 going to see a doctor in less than 60 minutes. I
10 bet there's no one in this room who could get that
11 from their own provider right now if they had a
12 complaint. And the way to do it is to call 911
13 and you have two vehicles come and get them. Yet
14 you just told us this morning that you have
15 ambulances at your ERs and they're waiting there
16 60 minutes, so if you come by ambulance sick and
17 you can't get seen in 60 minutes but you get a
18 promise this way you're going to be seen in less
19 than 60 minutes. So it's kind of paradoxical.
20 And I think it points out where we're at in our
21 systems of healthcare and how difficult it will be
22 for us to change, because everyone along the line
23 seems to have reasons they don't want to
24 participate. Too much extra work for the medics.

1 Suburban clinics aren't interested. The urban
2 clinics are interested, but they don't have enough
3 staff. It's like a litany of excuses, why they
4 can't. And I think we will all experience that in
5 the coming months and years as we try to do more
6 with less or to make sense out of what we're
7 doing.
8 And I think there is the sociologic issues are
9 very interesting, too, in terms of people's
10 expectations as -- it's very difficult behavioral
11 habits, how do you change them? But I commend you
12 for your efforts, and I think there's a lot here,
13 and I hope you write it up because I know you
14 learned a lot.
15 MR. ZEEK: As I said yesterday, I think it
16 really argues for more primary care, more and
17 better primary care, and I think it's something
18 the new administration ought to hear about as they
19 struggle to restructure the healthcare system.
20 MR. FAETH: Thank you very much, Tim.
21 Excellent presentation.
22 We're doing great with time here, moving right
23 along. So if there's no objections, we'll move
24 into the committee reports and we'll take a break

1 depending on how we're going.
2 DR. HENRY: You're not trying to compete with
3 Dr. Brevado, are you?
4 MR. FAETH: No, not at all.
5 Executive Committee met last night.
6 Basically, the core of what was discussed will be
7 contained within the individual committee reports
8 that you'll be hearing very shortly. There were
9 just two additional items that were briefly
10 discussed.
11 We did get some negative feedback about the
12 way the schedule is working. We did see some
13 people running around with a plate of food and
14 trying to make it from one meeting to the next
15 because they really didn't have an opportunity to
16 sit down. You know that this has been looked at
17 before and there's -- it's very difficult to
18 manage the time since there is just so much work
19 that has to be done in a very short amount of
20 time, but we are very open to suggestions. If
21 there's anybody that has a better sense of what
22 they feel the schedule should be, please let us
23 know and we'll try to implement it. Okay.
24 Also, with regard to the Finance Committee,

1 Mr. McEvoy has come to the end of his term. He
2 has done an enormous amount of work with a wealth
3 of experience and knowledge in that field as a
4 co-chair of the Finance Committee, and it has been
5 requested that if there is anybody that is a
6 SEMSCO member that has a finance background that
7 would like to get actively involved in that
8 committee, please come see me. We'd appreciate
9 your assistance.
10 From there I guess we'll move on to Medical
11 Standards. Is Dr. Marshall here?
12 DR. HENRY: No, but I'll give the report.
13 MR. FAETH: Okay, Dr. Henry. Thank you.
14 DR. HENRY: We have four items that I'm
15 bringing to your attention for votes. So first
16 will have to do with protocol. One is Nassau
17 County. They had some protocols addressing
18 diversion, redirection of ambulances and
19 administration of antidotes for nerve agents.
20 And the second was from the Mountain Lakes,
21 and it really addressed the anaphylaxis, and those
22 two were approved by SEMAC and come to you as
23 seconded motions. I don't know if there's any
24 discussion or any questions.

1 MR. FAETH: Any questions for Dr. Henry?
2 Donna, if we could have a roll call vote.
3 (Whereupon, a roll call vote was taken.)
4 MS. JOHNSON: Roll call complete.
5 DR. HENRY: Okay, thank you.
6 The next item was recommendation by SEMAC to
7 add Catemine to the state formulary. It's used
8 now by certain air medical crews, and there was a
9 discussion about the benefits of the drug and some
10 of the risks of the drug and potential uses in a
11 pre-hospital arena. There's no specific protocols
12 that are being addressed here. The first step is
13 to add it to the formulary.
14 We had people from the Bureau of Controlled
15 Substances present in the room to hear the
16 discussion, and I can tell you that there is
17 concern that -- about this drug from Dr. Morley,
18 Medical Director from the Health Department, as
19 there should be, as is appropriate for many of the
20 drugs we use, that there's careful detail in how
21 they're administered and under what situation.
22 But the vote for the SEMAC was to add it to
23 the formulary. So I don't know if that needs a
24 vote, what kind of vote that needs.

1 MR. WRONSKI: Roll call.
2 DR. HENRY: Are there any questions or
3 discussion? We have people at the table who
4 introduced the motion, Dr. Davidoff or Dr. Funk or
5 anyone else who wants to add comments? Okay.
6 MR. WRONSKI: If I can just explain how this
7 works, when we add a narcotic to the drug
8 formulary, the Bureau of Narcotics Enforcement
9 also, along with my Bureau, sends a report to the
10 Commissioner for consideration of adding a new
11 narcotic to pre-hospital care. But the first step
12 is for the SEMAC and the state Council to decide
13 whether or not you wish to do this and provide us
14 with why you wish to do this, and then the
15 Commissioner needs to sign off on that. So this
16 is the first step -- or the first step was
17 actually the SEMAC and the second step is your
18 Council to determine whether or not you agree with
19 that, and then we'll take it from there.
20 DR. HENRY: While a lot of times we refer to
21 controlled substances loosely as narcotics, it's
22 not a narcotic or an opioid in that sense of the
23 word. It's more like PCP. That's why it's
24 controlled, because I guess it has potential for

1 abuse.
2 MR. FAETH: Roll call.
3 (Whereupon, a roll call vote was taken.)
4 MS. JOHNSON: Roll call complete.
5 MR. FAETH: Motion again passed unanimously.
6 DR. HENRY: The next item, I don't know if it
7 needs a roll call vote, but I bring it to your
8 attention. It had to do with a request from the
9 Caris Foundation to assist children and others
10 with congenital adrenal hyperplasia and similar
11 conditions who under stress could be in a
12 life-threatening situation if they don't have
13 prompt administration of corticosteroids. And
14 SEMAC heard an address from them at the last
15 meeting and EMSC, and both of us agreed to talk
16 about this.
17 EMSC came back with a recommendation that
18 SEMAC endorsed and, in turn, we asked them to work
19 on it once more before we finalize the project,
20 but it's essentially this: That we would seek to
21 assist such children with administration of their
22 own medication if the caregivers had trouble doing
23 so; that we would be doing it under the following
24 circumstances: The child would be readily

1 identifiable with a medical bracelet or other
2 similar means of identifying them with the
3 problem, so it's a known patient with this
4 condition; they would exhibit findings typically
5 associated with actual or impending adrenal
6 insufficiency, and those would be identified and
7 include but not necessarily limited to fever,
8 shock, trauma, altered mental status,
9 hypoglycemia; that oxygen and fluids and
10 intravenous Dextrose, if needed, would have all
11 been initiated prior to this; and that the
12 ambulance or advance life support unit would have
13 been previously authorized by the appropriately --
14 appropriate REMAC and SEMAC to administer
15 hydrocortisone or methyl prednisone, which many of
16 us carry anyway, in appropriate doses, so that's
17 the recommendation.
18 And the numbers are, fortunately, small, but
19 for those who are affected, it can be very
20 significant. So we'll be moving forward with that
21 and we ask EMSC to put their narrative in protocol
22 formats we're more familiar with, and we'll
23 discuss that again at the SEMAC meeting. If
24 there's any questions or if it even needs a vote

1 at this point --
2 MR. WRONSKI: My recommendation would be for
3 the Council to vote on whether you support this
4 letter and promoting it as an information to the
5 regions, and then wait for a roll call vote when
6 and if we approve a state protocol in this regard
7 or a modification of the state protocol. Right
8 now it doesn't count, so agree to support, as
9 SEMAC had, the EMSC Committee.
10 DR. HENRY: To show you -- I mean, to draw a
11 parallel, I think the educational programs we have
12 for assisting with medications would be
13 promulgated for this medication, so people would
14 be taught, as they are for epinephrine and other
15 drugs in the EMT curriculum, how to assist people
16 with their own medication. It would be that kind
17 of format. We predict potentially an hour CME.
18 That was the thought at our meeting, if that's
19 helpful.
20 MR. FAETH: Okay, then, what we'll do here is
21 a show of hands. All those in support of the
22 initiative to assist the patient with adrenal
23 corticosteroids for those patients under those
24 guidelines, a show of hands would be yes. All

1 those against? Any abstentions? So moved.
2 DR. HENRY: Another point of business was a
3 recommendation from EMS for children that all
4 ambulance carry copies of the BLS protocols and
5 the regional ALS protocols, so it sounds like a
6 no-brainer. You would think most would have it,
7 but I guess not. I don't know if there is a need
8 to even act on that, but it seemed logical.
9 That's pretty hard for anyone to remember the
10 content of 200 pages, but maybe some of us can.
11 So I don't know if that needs action here, but
12 that was a letter that came forward.
13 MR. McEVOY: I would recommend you do act on
14 it, because I'm not so sure that's as obvious as
15 it seems that it's being done.
16 DR. HENRY: Okay. Well, then, I bring it to
17 the SEMSCO with our recommendation of SEMAC.
18 MR. FAETH: I would adopt that recommendation.
19 I'd also like to add a friendly amendment to that,
20 especially since so many regions have so many
21 different variations of protocols, that included
22 in whatever communication we make to the
23 individual providers, that we also strongly
24 recommend that the system or agency that these

1 individuals work under on some type of regular
2 basis internally review and test your members on
3 their protocol knowledge. Obviously, we're not
4 mandating that, but I think it would be a good
5 idea, because all too often people are either en
6 route to their call furiously looking through
7 their protocol book for the type of call type
8 they're responding to, or sometimes even on the
9 scene, which really shouldn't be happening. So we
10 know how dynamic medicine is where these protocols
11 are constantly changing and people need to be
12 updated. It might be a good idea, so do I have
13 anybody accept my friendly amendment?
14 MS. COMPAS: Second.
15 MR. FAETH: Ms. Compas, thank you. All in
16 favor? Any opposed? Any abstentions? Should
17 this be in the form of a letter from myself or
18 from Dr. Henry?
19 DR. HENRY: Well, I don't know how friendly it
20 was. You're asking everyone to be tested.
21 MR. WRONSKI: We can vote, too.
22 MR. FAETH: All right. Thank you for putting
23 that together.
24 DR. HENRY: Some other items, some are for

1 information. I want to thank Sharon Schmento for
2 putting together a draft of the ALS standards of
3 care in a format that we're familiar with, a
4 tremendous amount of industry and willingness to
5 move this topic forward, so it's a work in
6 progress, but it's progressed significantly since
7 Sharon has worked on it. So I thank her.
8 I made a request to all the regions that they
9 send in their definition of "diversion," if it
10 takes place in their region and that they tell us
11 for a month how often it's occurring at what
12 institutions. We had Dr. Morley and Mr. Cook at
13 our meeting. Dr. Morley is the Medical Director
14 for the Office of Health Systems in the
15 Department. He chairs a group on crowding in
16 hospitals. He's going to be making site visits to
17 the hospitals now.
18 Here we have a definition in Nassau that's on
19 paper. We heard from Tim earlier that in
20 Rochester the hospitals were on diversion today,
21 is that right? I don't know what the definition
22 is there. I don't know in Syracuse what they do.
23 We don't know how often it occurs. Can't get
24 patients off the ambulance stretchers, bringing

1 people in with flu, sounds like something we
2 should know what's going on, so that's my request.
3 And I would hope the agencies would do this with
4 REMSCO, because we need that information. It
5 can't be so loose that it's so subjective that
6 whenever hospitals decide to go on diversion, they
7 call in and the ambulance goes somewhere else. It
8 shouldn't be that loose, and we should know how
9 often it's occurring.
10 Then we're going to address the issue of
11 tourniquets, so tourniquets, as Dr. McEvoy may
12 want to add to this, is provocative now because
13 the answers to the tests vary depending on what
14 level of provider you are, so that's not a good
15 situation, because everyone is responsible for
16 bleeding control. So you want to express that,
17 Mike, a little bit, just so people understand the
18 issue?
19 MR. McEVOY: I think we had discussed the
20 national registry having changed their testing for
21 practical skills last year, which, essentially,
22 they just abruptly adopted PHTLS guidelines that
23 say control bleeding with direct pressure and, if
24 that fails, go to a tourniquet. And what's

1 happened in New York State is at the paramedic
2 level we use the national registry testing sheets,
3 and at the other levels we have the New York State
4 testing sheets. So I discovered when I took my
5 practical skills exam last Saturday that my
6 bleeding control station is direct pressure and
7 then apply a tourniquet. And even the examiner
8 was, like, what, what, what, and suddenly
9 discovered now in New York paramedics have a
10 different method of bleeding control than all the
11 other levels of providers.
12 So when I talked about this at SEMAC
13 yesterday, I said this really behooves us to take
14 a look at what the national registry has done and
15 try to apply some consistency to our New York
16 guidelines.
17 DR. HENRY: So we're going to address that at
18 the next SEMAC meeting. Tourniquet has always
19 been thought of as a resort to use to stop
20 bleeding, but where they're applied now and how
21 much time people spend trying to elevate, millot
22 the proximal artery before they go to it, whether
23 that's effective or not, that step would be
24 eliminated, depending on one's philosophy of

1 teaching, so we have to keep our teaching
2 consistent. So we're going to address that
3 specifically at SEMAC with the concept we would
4 direct proper treatment and then we would educate
5 and test accordingly, so that's -- welcome your
6 input.
7 Also, I was glad Dr. Morley was here because
8 we talked about ST elevation MI and the lack of
9 such state-wide protocols, and that was
10 precipitated by the report Dr. Kaufman gave on our
11 ACEP report card, that when you look nationally at
12 New York, there's no direction on a state-wide
13 basis to direct percutaneous intervention for ST
14 elevation MI, so we talked about this ad nauseum
15 here.
16 And I was glad Dr. Morley was there because he
17 might have some influence on the time line when we
18 do this formally. The advantage to doing it
19 formally is we are able to get much richer data
20 than we will on the ad hoc basis like we are now.
21 And that's the way to go with something so
22 serious. So I was appreciative that he was able
23 to be there.
24 I think that's my report.

1 MR. FAETH: Thank you.
2 MR. REISNER: Dr. Henry, was there any
3 discussion on Blood and Online Medical Command?
4 DR. HENRY: Okay. Blood, we had a short
5 discussion as to where that was at, and I was
6 hoping we'd get to see some of the forms. If you
7 read our minutes from the last time, we wanted to
8 see more detail in the preliminary regs, like some
9 of the forms that were going to be forthcoming
10 subsequent to the regulations, people would sign
11 off. Unfortunately, Lee's computer was locked and
12 no one knew the password, so we couldn't see those
13 forms. So that's the status. I don't know if
14 Mr. Wronski or --
15 MR. WRONSKI: The status is that the
16 preliminary regs were re-reviewed by the Blood
17 Council, and the Blood Council, while it had some
18 questions regarding our -- supported the regs,
19 didn't have, I believe, any recommended changes to
20 the regs, but they did have recommended changes to
21 some of the supporting documentation and some
22 questions. So myself and Lee and Andrew Johnson
23 and Dr. Young -- and, actually, I missed the
24 meeting, but the people I just mentioned were all

1 at the meeting to discuss with Dr. Linden and her
2 staff the questions from the Blood Council, and
3 they made some revisions which will be shared with
4 everyone, again, not to the regs, but to the
5 supporting documentation. The regs, though, are
6 going to move to the next step, and that's review
7 by Gore, and then, ultimately, the publication
8 formally, and we are hoping we can get that
9 approved in the process no later than early next
10 year. It's a long process, but we are pushing it.
11 Again, we'll share with you the policies and
12 forms because they can be changed by us or -- let
13 me back up. We can recommend changes to them, to
14 Dr. Linden and her staff, who are primarily
15 responsible for the administration and use of
16 blood products, but we'll do that. I'll have to
17 talk to my acting deputy director and get her
18 password. And the reason we didn't get it is she
19 was in flight to Washington.
20 MS. VESELY: There are two things. First one
21 with -- my computer died, I need to bring it back
22 up -- there's an article that I got from the NEA
23 that discusses and talks about the diversion
24 problems, that it's not just here in New York;

1 it's nationwide. And they don't know nationwide
2 why it's happening or the frequency of why it's
3 happening, so it's something that is being looked
4 at across the nation, by not just us now.
5 And the other thing is with the blood
6 products, there was a statement in there that the
7 hospitals would have to contract with agencies
8 that are going to be doing that. Is that just an
9 agreement that they will follow these rules, not
10 really a contract, per se?
11 MR. WRONSKI: A contract is an agreement, and
12 that can be in a letter. It can be very simple.
13 We'll provide a model.
14 MS. VESELY: The director of our blood bank
15 was asking, and I said I would get clarification.
16 MR. WRONSKI: Yeah, we're not looking -- I
17 mean, if --
18 MS. VESELY: That's what I assumed, but I can
19 spell assume.
20 MR. WRONSKI: I can't say, any specific
21 institution, what they may require. That's always
22 going to be up to an institution. But we're not
23 going to require a certified contract, all right,
24 in place. We just need to know that you come to

1 an agreement about how that will work, and that
2 can really be very simply a single-page agreement,
3 how the blood will change hands and how it will
4 move.
5 DR. HENRY: And Mr. Reisner asked about was
6 there discussion about medical control. There was
7 a robust discussion about medical controls. They
8 had a conference call in between, and a lot of
9 people participated. And it was an important
10 discussion because there's some variation around
11 the state in who gives medical control. And it's
12 very important that everyone keep that in mind,
13 when you talk about protocols with medical control
14 options, who is the medical control, what kind --
15 what do they bring to the table and what's their
16 depth of knowledge if you get into, you know,
17 subtle conditions or atypical presentations, so
18 that's going to continue.
19 MR. FAETH: Mr. Zeek.
20 MR. ZEEK: Just a couple things. As the one
21 provider member who was invited to the original
22 Blood meeting, I certainly hope we'll get to
23 review the forms and the regulations in September
24 so that we can -- the providers can assure

1 everybody else that it's doable. I think it will
2 be, but -- because we had good cooperation here,
3 but I think -- I think we really should review
4 that stuff in September.
5 MR. WRONSKI: If you -- we'll find out why you
6 don't have a copy. The regs were actually shared,
7 and I'll double-check, but I don't believe they've
8 changed at all from the last mailing, so those
9 regs are the regs, as I understand it. The forms
10 and policies have been kicked around a little bit,
11 and we'll share that with you.
12 MR. ZEEK: Okay, yeah, I did see the original
13 mailer.
14 Question for Dr. Henry. You said you'd like
15 regions to send in their definition of "diversion"
16 to the Department. Who is going to own that in
17 the Department, and collect that information, just
18 so we can tell the regions?
19 MR. FAETH: Good question.
20 DR. HENRY: How about your associate?
21 MR. WRONSKI: Yes. Actually, what I will ask
22 you to do is send it to Lee Burns' attention, and
23 she would have gotten this whether she had the
24 title or not. But, yeah, what I would ask is that

1 each region -- each region may have a complex
2 problem here because she may have multiple
3 counties that have different definitions or towns
4 that have different definitions of "diversion."
5 What we would ask you to do, if you know
6 already, just put that in a simple letter to us,
7 but -- you know, you can do this by e-mail,
8 whatever information you can get from within your
9 region.
10 And maybe there's a consistency. Maybe you
11 have a standard definition. And I wouldn't doubt
12 that there are going to be some areas that don't
13 really have a formal definition as to what that
14 might mean. But, as Dr. Henry alluded to, you
15 know, there is a formal definition in the law
16 regarding when a hospital should go on diversion,
17 but what we're looking for is what does the EMS
18 system consider a definition. And we should take
19 a look at that. This will be a good learning
20 lesson.
21 How you get the other piece that Dr. Henry has
22 asked for is how many times did your system go to
23 diversion. Depending on the region, you may or
24 may not have access to it, but I would ask you to

1 ask. You know your system players. If you're
2 lucky enough and you have one major one, you can
3 work with them and ask if they can in any given
4 one-month period -- and my suggestion is month of
5 August, unless there is recommendation to do it a
6 little later, but --
7 DR. HENRY: There's one we've just done, so we
8 can look at it and put it together before the next
9 meeting.
10 MR. WRONSKI: All right. Is July something --
11 again, it's a time frame. We're in June. Will
12 you be able to in time reach out and see if you
13 can get contact to your various 911 centers and
14 ask them that? And would they be willing to give
15 you the numbers of times?
16 And I have to ask, as we get down into the
17 weeds here, but do you want percentage of time
18 from your overall call volume, or are you asking
19 the actual numbers, you know, 10, 20, a hundred, a
20 thousand. And if you do that, then I would say
21 that you also really do have to tell us what your
22 total volume is of the number of calls you're
23 sending to a hospital, so when you tell us a
24 thousand were redirected or diverted, you know

1 what it means within your system.
2 So maybe offline we'll have a conversation
3 about how to do that, and I will send within the
4 next week a letter to all the regions, the program
5 agencies saying here is how we're asking you to do
6 this and see if you can do it and do it for the
7 month of July. Any comments on that or requests?
8 MR. BLUM: I'm just concerned, without having
9 a formula that's spelled out by you, you can get
10 different pieces.
11 MR. WRONSKI: Right. We'll send you a letter,
12 then, asking specifically -- more specifics on how
13 to do this, and if you can, you can. If you
14 can't, you can't. But we do ask you to give it a
15 try and see if you can get that for us.
16 MR. FAETH: I would like to add one personal
17 note on the diversions. You have the formal
18 diversions where the administration notifies the
19 system providers. Then there's also an informal
20 diversion that goes on quite frequently where the
21 actual ER staff advises the providers that "please
22 do not come back here for a while because we don't
23 have beds; we don't have monitors; and I don't
24 know why the administration hasn't put us out yet,

1 but you're killing us." And that's also something
2 that we can't really -- I don't think we can
3 document that, but that is also occurring on a
4 frequent basis.
5 Any other questions for Dr. Henry? Okay,
6 thank you, Dr. Henry.
7 Still doing great on time. Everybody good for
8 one committee -- one more committee report? All
9 right. How about we move to Education and
10 Training. Mr. Wedge.
11 MR. WEDGE: We have one seconded motion to
12 bring before the group, if it comes up here. That
13 motion is to allow 100 percent of the core content
14 for recertification to be online and to establish
15 a TAG to create standards in a content-approval
16 process.
17 MR. FAETH: Okay. Motion for 100 percent of
18 the core content to be done online.
19 MR. WEDGE: Yes.
20 MR. FAETH: Is there any discussion on the
21 seconded motion?
22 MR. BRANDT: Is that for both levels, ALS and
23 BLS?
24 MR. FAETH: Edgar?

1 MR. WEDGE: The way it was discussed
2 yesterday, yes.
3 MR. FAETH: Debbie.
4 DR. FUNK: Would there be any specific
5 requirements, such as a quiz, a test, any
6 requirements for there to be interaction between
7 the provider taking the program and the person
8 giving the program, or this is sign up, read
9 something, say I did it?
10 MR. WEDGE: This was discussed, and it is
11 going to be up to this TAG to set the parameters
12 of what needs to be done, and the TAG has already
13 been formed.
14 DR. FUNK: So what we're voting on is that the
15 TAG would continue to look at the issue and define
16 it more specifically?
17 MR. WEDGE: Right now you're only allowed, I
18 think, 12 hours, and this is to go to 100 percent.
19 DR. FUNK: I would say it's a great concept,
20 but I would hesitate to allow it to be just
21 blanket get on a computer and you don't ever have
22 to learn anything again. Not that there are not
23 great computer programs and core content programs
24 that you can do, but some sort of definition of

1 what the requirements are for online course
2 content would be useful.
3 MR. WEDGE: Understood.
4 MR. WRONSKI: Thank you for the follow-up. If
5 I could follow up, Dr. Funk must have read my
6 mind, and I've already spoken to Edgar about this.
7 The Department has serious concerns about
8 going 100 percent online. As of this moment there
9 is no way the Department will approve that, so
10 that's number one.
11 Number two, that doesn't mean you can't vote
12 and recommend that this TAG meet and come up with
13 proposed ways to determine how to evaluate that
14 and set criteria that are doable and we trust.
15 My job, just as yours, is to assure that
16 providers who are recertified, whether through the
17 traditional program or through a CME program,
18 have, in fact, taken adequate training to refresh
19 their skills and their knowledge base.
20 CME programs are the education tool most
21 looked at today and the one most promoted in every
22 field of education as the future. And there will
23 come a time when, you know, classrooms may not
24 exist. That in some ways happen today with some

1 degree programs. I can tell you that I know of no
2 profession that gives those degree programs that
3 are done solely online any credibility.
4 So if we move in the direction of a hundred
5 percent recertification using the CME, there has
6 to be a very stringent model put in place for how
7 that CME will be confirmed, what it should
8 include, and, you know, Edgar has advised me
9 that's what the TAG wants to do. But I need to
10 put on the record that unless we're convinced that
11 this is not only good recommendations but that
12 it's doable, because it will be up to largely my
13 staff ultimately to assure that programs are good,
14 and I do not have the staff to review on any kind
15 of individual basis CME programs from across the
16 state or certify them. So they'll have to be
17 recommendations coming out of the staff, how you
18 would practically do this. How would we implement
19 such a program and do so in a partnership with the
20 regions. So I'm not saying this can't happen,
21 although I already said it can't, so it's one of
22 those paradoxical things that Dr. Henry talked
23 about.
24 But the Department is going to need a very

1 strong argument and plan, which I hope the TAG
2 will come up with, which shows how a hundred
3 percent could be done safely and that we can be
4 assured that our providers are trained properly
5 and every three years recertified appropriately so
6 that our patients are getting the appropriate
7 care.
8 So I put on the table that it's something you
9 can certainly vote on and recommend and do some
10 work on, but the Department is very skeptical, at
11 this point, anyway, until we see a product in more
12 detail that could be done safely currently, but we
13 could be wrong.
14 MR. FAETH: Dr. Funk.
15 DR. FUNK: Now that I've brought the issue up,
16 I can tell you that I know firsthand that there
17 are very good online training programs for
18 continuing education. The Life Net of New York
19 program -- many of you know -- has six helicopters
20 across the state. It is impossible to bring all
21 of our providers together in one physical
22 geographic location to do continuing education.
23 The majority of our self-imposed recert -- not
24 recertification but continuing education for our

1 providers is done on a computer. Much of it is a
2 webcast lecture so that there is ongoing
3 interaction between the speaker and the providers
4 who have logged in and are participating. Some of
5 it is pre-recorded. And with -- all of it has
6 post tests and the ability to have realtime
7 interaction with the speaker, so I know that there
8 are great ways to do online education. And in a
9 state as geographically diverse as New York State,
10 it's something we really need to look at. And I
11 think it's very feasible.
12 But I would suggest that we ask the Education
13 and Training Committee to put together specifics
14 and then bring it back. You know, this is what we
15 recommend for online content and we recommend that
16 it be 100 percent for the recertification
17 programs. That would, I think, probably satisfy
18 what everybody's concerns are.
19 MR. FAETH: Yes, Mike.
20 MR. MURPHY: As chair of the regional TAG and
21 as a member of the new TAG that's formed, our task
22 is going to make sure that the online training
23 actually exceeds what we currently have. You
24 know, what we currently have in a brick-and-mortar

1 classroom is a lecture that is done and it's
2 debatable whether there's any validation on the
3 retention of the material by the student. What
4 the online platforms allow us to do is have the
5 student look -- and, also, remember what we're
6 talking about is didactic material only regarding
7 to the core. You still have the practical skills
8 verification component, either by direct
9 observation QI as part of the normal CME program,
10 so it's strictly looking at didactic material.
11 And we're going to be looking at, on the TAG, of
12 presenting that didactic material, and then also
13 absolutely having post tests, perhaps even
14 pretests, so that there is definitely a retention
15 in that material.
16 Again, one of the problems that we see we're
17 faced with across the state is the availability of
18 education for providers, and as a retention tool
19 to people to maintain their certification, it
20 might be a little easier if they're able to do it
21 online.
22 There's several organizations that use
23 tab-ready PCRs out in the field and they're
24 Internet capable, so during downtown providers

1 could do online CME programs. So what the TAG is
2 going to look at is several platforms that are out
3 there that actually are quite good and also have
4 post tests.
5 Also, the individual training agency officer
6 can look at the person's performance on those
7 online programs, actually see what their scores
8 are, what their trends are in particular subject
9 matter and, if need be, provide additional
10 remediation to those folks based on their scores.
11 So, in my opinion, and, again, it's contrary,
12 probably, to the Bureau's, but I think that the
13 online program would probably give us greater
14 retention and verification of that retention than
15 we currently have now in the current CME program.
16 MR. FAETH: Yes, Mr. LaMarca.
17 MR. LaMARCA: Just to echo something Mike said
18 here, I think that people who don't teach or
19 haven't taken, perhaps, quote, let's say, an "EMT
20 refresher program" don't realize that even in
21 the -- well, the benchmark was sitting down for
22 the entire refresher, not even a challenge
23 component. But if you take a look at our syllabus
24 for those nights that you're attending, there's

1 certain nights we're covering six major topics in
2 a three-hour time span. They're getting not
3 enough time in any one of the six to really do
4 them justice.
5 What use of online education does for us, too,
6 is the fact that we can take those six modules and
7 expand them out and test them on those six
8 modules. So just -- not for discussion right now,
9 but just in case you're thinking that the
10 benchmark really should be that sit-down in a
11 brick-and-mortar classroom, we're probably doing
12 them a disservice in certain cases that we could
13 perhaps address here.
14 MR. FAETH: Yes, Ms. Vesely.
15 MS. VESELY: Just a point of clarification,
16 New York nurses can get their complete degree
17 online, and New York is one of the only states
18 that allows reciprocity in all states. Because
19 they've gotten it online doesn't make any
20 difference, so that is one profession that does
21 allow complete online training.
22 MR. FAETH: Mr. Zeek.
23 MR. ZEEK: I have two questions. I presume
24 that this is for recertification and not for

1 original certification?
2 MR. WEDGE: That's correct.
3 MR. ZEEK: And I also wonder what the impact
4 might be on core sponsors who currently depend on
5 a certain amount of recertification classes.
6 Otherwise, I think it's a great idea.
7 MR. WRONSKI: Let me repeat. I didn't say we
8 don't like the idea of CME. We do. And I may
9 have Karen speak in a minute -- Ms. Meggenhofen
10 come up here -- but -- and we've allowed a number
11 of programs with CMEs, and we do see it as the
12 wave of the future and, actually, the future is
13 here. It's interesting to note the nurses accept
14 a hundred percent. I did not know that.
15 The issue isn't so much whether CME can be --
16 can work. The issue is how that would work in a
17 system such as our own. Dr. Funk talks about a
18 very rich system that she supports, but the reason
19 she can do that is the nature of that particular
20 service and the resources they can bring to bear
21 to make it work. So the question is how do we
22 implement something like this on a state-wide
23 basis?
24 The other question is a real serious one, and

1 it is what is the effect on the sponsors? How
2 would this work with sponsors? And do you now
3 have -- because, really, the world of electronics
4 -- CME opens up doors to geography and opens --
5 and kind of drops geographic boundaries
6 potentially in the future, where you can have a
7 mega-sponsor who might provide recert courses to
8 anybody in the state, and they may be located in
9 one geographic area. And that may or may not be a
10 good thing, but -- Karen?
11 MS. MEGGENHOFEN: I just had a frightening
12 thought, but that's all right.
13 I briefly just wanted to make sure that the
14 terminology we're using here isn't somewhat
15 confusing. The motion really is purely CME, and
16 it's the core portion of the CME which, obviously,
17 as you mention, is the only place that the core
18 sponsor can be reimbursed.
19 The other piece that we do have to remember
20 when we work on these plans is that it has to be
21 overseen by a CIC, so while, you know, there are
22 ways to do this and we have programs going --
23 ongoing now that we've -- that have put in
24 proposals and we've reviewed and allowed to do

1 this, in those cases the CIC still is very much
2 involved. So, you know, it can't be that
3 situation where you choose whatever it is you
4 happen to want to take that you think fits into
5 the criteria of core. It's still going to have to
6 have some control, and we have to make sure that
7 we keep that. But it's not a regular refresher
8 course. It's not an original course. This is
9 purely talking about the CME program at this
10 point.
11 MR. FAETH: Mr. Hassett?
12 MR. HASSETT: Yes. Just -- we have not
13 reached the Finance Committee's report and, when
14 we do, I think we may want to consider something
15 of this nature, at least for the advanced skills,
16 since we are projecting the possibility of not
17 funding our recertification training for the CC's
18 and the paramedics. And if we're not going to pay
19 for it, then we need to give them an alternative
20 way of doing it so that they don't have to lay out
21 as much out of their own pocket.
22 MR. FAETH: Mr. Delagi.
23 MR. DELAGI: As an online instructor in the
24 undergraduate program in the SUNY system, I

1 certainly appreciate the value of online education
2 and generally support the idea. Having not been
3 part of your discussions at the education
4 committee level, I'd certainly be more interested
5 in hearing about what Ms. Meggenhofen just alluded
6 to, whether or not that was discussed in the
7 context of if a student can sit at their home
8 computer and get all of their core content online,
9 just how will a CIC oversee that. And I'd really
10 like to hear more about the potential for
11 reimbursement potential for core sponsors,
12 notwithstanding Mr. Hassett's comments. I don't
13 know if your discussions got that far.
14 MR. MURPHY: The CIC component was never left
15 out. We are going to put into the standards that,
16 obviously, just as in a core program that might be
17 done by lecture, the content of the platform has
18 to be approved and overseen by a CIC and follow
19 the New York State curriculum, and that would
20 either be done by either the core sponsor doing
21 the -- overseeing the online CME, like several
22 agents are doing, or having a CIC overseeing the
23 agency's CME program as they do currently when
24 they do lectures. So that would be a requirement.

1 MR. FAETH: Thank you, Mike. Any other
2 comments?
3 I do have one comment myself. I am a
4 supporter of online education. It does allow the
5 student to work at their own pace. We have
6 different learning abilities. And it also
7 eliminates the issue where a student is absent
8 from the class that they have all that material
9 there in front of them. They can work at their
10 own pace. They can go back and review things, and
11 you don't have to hold up an entire class because
12 you're not grasping something. So -- and people
13 can also -- working two jobs and whatnot, they can
14 actually do that while they're working, too, so
15 where there's been issues with increased training
16 requirements and people not having enough time to
17 attend classes, I definitely do see the benefit.
18 But we do have a motion on the floor. As it
19 stands, you're saying that this is a hundred
20 percent core lecture content, and then the person
21 would come in for their practical exam skills to
22 the classroom, is that correct?
23 MR. WEDGE: That's correct. Skills have to be
24 face-to-face.

1 MR. FAETH: Is anybody -- based on the
2 discussion we've had here, is anybody looking to
3 make a friendly amendment to that motion, or are
4 we going to vote on it as it stands?
5 MR. HASSETT: A point of order. I don't
6 believe you can do a friendly amendment to a
7 seconded motion since the committee moved and
8 seconded that motion forward. You have to vote on
9 this motion as it stands and then make a new
10 motion.
11 One other item I would just make on that is
12 that if you look at the motion, you're really only
13 approving a concept, because until the TAG
14 develops all the details of it and that's approved
15 by this body, it really can't move forward. So
16 it's really just a motion to approve the concept
17 of a hundred percent online recertification.
18 MR. FAETH: Okay. I stand corrected. Thank
19 you, Mr. Hassett.
20 Yes, Mr. Reisner.
21 MR. REISNER: Just one final comment. I want
22 to applaud the Education Committee for moving
23 forward. This is long overdue. There's a lot of
24 work yet to be done, but the committee is on the

1 right track, and let's get the concept approved
2 and move on.
3 MR. FAETH: Okay. Anything further? Yes.
4 MR. BRANDT: Could you read the actual motion
5 that we're voting on? I'm sorry, it's bifocals.
6 MR. WEDGE: Motion to allow 100 percent of
7 core content to be completed online and to
8 establish a TAG to create standards and a content
9 approval process.
10 MR. FAETH: Okay. All in favor? Motion as
11 stated? Any opposition? Anybody opposed? Any
12 abstentions. Motion passes unanimously.
13 MR. WEDGE: Thank you.
14 Some other items that were discussed
15 yesterday, apparently, there's still a number of
16 people or organizations out there who are still
17 not vouchering for the practical skills exam. All
18 of those are eligible for funding. We were given
19 some staff re-assignments. There's a couple of
20 new policies that are out. One is 95 -- excuse me
21 -- 0905, which is concerning those who are unable
22 to sign their student applications. The
23 current -- the new policy says that they're not
24 going to be able to sit for any test, not even a

1 pretest until that is -- or a challenge exam until
2 that has been rectified by the Department.
3 There's a new funding policy out, 0906, and it
4 talks in there about how the money can be spent,
5 what you can't spend it on. Currently, there's no
6 change in reimbursement rates. However, that may
7 change when Mr. McEvoy makes his presentation.
8 The course applications need to be in to the
9 Bureau now eight weeks prior to the practical
10 exam. For some of those short courses, that may
11 not be that long, we are going to have to have the
12 pre-registration and the registration sent in to
13 the Bureau prior to the course beginning.
14 The way funds are going to be disbursed has
15 been changed. It's going to be on a
16 student-by-student basis, so every course app or
17 student application must be forwarded to the
18 Department so they can get it into the system, but
19 this is going to be how you're going to be
20 reimbursed for the courses that you've taught.
21 We were given a copy of a little booklet from
22 the New York State Office of Mental Retardation
23 and Development Disabilities called ON THE SCENE,
24 AN INFORMED FIRST RESPONSE AND AUTISM. I would

1 suggest that you go online and you can get this.
2 That's where we got it from.
3 And I believe that's all I have at the moment.
4 MR. FAETH: Thank you, Mr. Wedge. Any
5 questions for Education and Training? Okay.
6 MR. WRONSKI: I would just like to make a
7 comment and thank Mr. Wedge and thank the
8 Education Committee and the prior chair for all
9 the work done in that committee. And I think it
10 points out that probably one of the most important
11 committees in this -- you're all important
12 committees, but, frankly, we build ourselves on
13 education, and so I appreciate the work and the
14 work you're going to do in the future.
15 And, Deb, thank you very much for the many
16 years you put into the education chair.
17 MR. FAETH: Yes, thank you, Deb.
18 (Applause)
19 MR. FAETH: Seeing no further questions, I
20 think we'll take this opportunity to stretch our
21 legs and take a break. Have a ten-minute break
22 and come on back.
23 (Recess.)
24 MR. FAETH: I purposely skipped Finance

1 earlier because I know it's going to possibly be a
2 hotbed of discussion and I didn't want to prevent
3 you from getting your refreshed coffee or
4 anything. Is Mr. McEvoy here?
5 MR. LEWIS: He's tied up in a closet.
6 MR. FAETH: Okay, Mike, you got your flack
7 jacket?
8 MR. McEVOY: Yep.
9 MR. FAETH: All right. Move the agenda to
10 Finance. Mr. McEvoy.
11 MR. McEVOY: All right. I remind everyone
12 that Warren is armed, and he has his eye on me.
13 MR. LEWIS: Designated shooter.
14 MR. McEVOY: The Finance Committee met on
15 Monday night, and our prime purpose was to review
16 the templates that were submitted for the
17 2010-2011 budget, and I want to just give you a
18 preliminary idea of what happened with that. Of
19 the requests that were received, we had set a
20 threshold this year of zero percent for an
21 increase, and we screened anybody who asked for
22 more than zero percent increase. That was ten of
23 the submissions from program agencies and regional
24 councils. Of those, Finance Committee found all

1 but one of the increases to be adequately
2 justified.
3 The one that we reduced was the FDNY program
4 agency was reduced by $23,476, which I think we
5 did last year, also, as a cost of shredding
6 electronic PCRs, which we didn't feel was
7 adequately justified because electronic PCRs don't
8 appear to need shredding.
9 That left us what we'll probably bring to you
10 in September as a budget of -- totaling
11 $23,539,320, which is roughly $56,000 less than
12 the budget that we submitted for the last fiscal
13 year, so we'll bring that to you as a seconded
14 motion from the committee with the detail of that
15 after we have a chance to wordsmith it over the
16 summer.
17 So the other item that we spent a couple of
18 hours working on, which, as John Hassett alluded
19 to, is somewhat contentious, is restructuring of
20 the course funding. This is a project that has
21 been ongoing now for a little over six months. It
22 started out with a survey of core sponsors that
23 was done by the Finance Committee, had a very
24 large return from core sponsors, where we asked

1 them initially to suggest to us what was their
2 cost to actually run the training at each one of
3 the levels. And we asked them for what their cost
4 was to run the course and their cost to test the
5 students.
6 We then went back several times, especially to
7 the ALS core sponsors, to inquire about what were
8 the sources of the revenue that they were
9 collecting in order to run the courses, whether
10 they were charging tuition or whether they were
11 using state reimbursement.
12 We also struggled quite a bit with attempting
13 to figure out what we're currently spending at
14 each one of the levels, and the complexity of that
15 is twofold; one of which is, as you're familiar,
16 in the budget we submit a cost for BLS training
17 and we submit a cost for ALS training, and that's
18 basically how the division of budget looks at it.
19 So if we were to take the BLS and ask them, "How
20 much did you spend on certified first responder
21 original practical skills exams?" they would say,
22 "Is that BLS or ALS?" And then they would not
23 know the detail of that particular item.
24 It's also difficult for the Bureau to track

1 that because of the way that the vouchers come in
2 from the core sponsors. And, as a consequence,
3 what we ended up doing essentially was to look at
4 what -- the total amounts that were spent in those
5 categories over the last six years and then, using
6 historical data from surveys that the Finance
7 Committee has done in the last six years, as well
8 as the annual templates that are submitted from
9 the regional program agencies and regional
10 councils and Bureau data and division of budget
11 data, we were able to create a huge pie and
12 determine, over a six-year period, what percentage
13 of that pie went to each one of the expenses that
14 are associated with running the training program.
15 From that we were able to extrapolate the current
16 cost of courses; couple that with information that
17 came back from core sponsors as to what they
18 actually -- what their costs are to run those
19 programs.
20 And then we at our last meeting restructured
21 the cost of the BLS components of that. And I
22 remind you that under statute the monies are to be
23 spent to fully fund a course of BLS training, the
24 cost of BLS training in New York State, with

1 monies that remain used to fund the costs of ALS
2 training. And so with that in mind we made the
3 readjustments at the last meeting to increase the
4 funding and in some cases decrease funding to core
5 sponsors to better reflect what their costs are to
6 run the first responder and the EMT original and
7 refresher training in New York State.
8 We were then faced with a little over $1.1
9 million that we had to come up with from someplace
10 else. So on Monday night we sat down and did some
11 restructuring of the funding at the ALS course
12 levels. And when we had concluded doing that, it
13 was suggested that we take our recommendations in
14 draft form, and I repeat, draft, draft, draft,
15 draft, draft form, to the Training and Education
16 Committee as well as to the Systems Committee to
17 get some feedback on what the impact of that might
18 be, one, on education, and, two, on the systems.
19 And the summary of that I actually presented
20 with numbers yesterday to Training & Ed, which is
21 where a lot of the rumors of flying bananas,
22 oranges and rotten eggs comes from, as well as to
23 Systems, who suggested that I may need a trauma
24 center if I wanted to go through with the

1 recommendations.
2 But our purpose in doing that was basically to
3 let people have a look at what we're thinking
4 about doing and to get some feedback about that.
5 And the major highlights of it were zeroing out
6 the reimbursement for training at the EMT original
7 and the EMT -- excuse me -- EMT intermediate
8 original and EMT intermediate refresher level as
9 well as at the paramedic original and the CC
10 original levels.
11 We also smoothed out the reimbursement at the
12 CC refresher and the paramedic refresher levels to
13 equal what's being paid in pilot or the CEU
14 refresher program so that there's not an incentive
15 for a core sponsor to encourage people to take a
16 conventional refresher versus being in a
17 continuing ed refresher program, which there is
18 some incentive now to sway people towards a
19 conventional program because it reimburses a
20 little bit more. It also reimburses more than
21 what sponsors' costs are to actually run that,
22 which is part of the decision-making strategy.
23 So, ultimately, with that floated out, what
24 we're asking for is for core sponsors and for

1 folks who are involved in the Systems and the
2 Education and Training to come back to us over the
3 summer with some commentary about that, and we'll
4 look at it again in September. We're not using
5 any strategy as to when we want to implement this.
6 There's obviously a great deal of work that
7 needs to go into the Finance Committee's thought
8 process about how, finally, this is going to come
9 out. And I think ultimately what you're going to
10 see is a couple more drafts of this before
11 something gets implemented.
12 And I'll just make a couple points. One is
13 that our return on the core sponsor survey was one
14 of the largest returns percentage-wise that we've
15 ever gotten from core sponsors. I think now that
16 we've proposed zeroing out some of the funding at
17 the ALS levels, we'll have an even better return
18 of responses from both the Systems people and the
19 people in Training and Ed, and that's what we're
20 looking for. We really want to look at what the
21 impact is on the system.
22 And I think we have to balance that with what
23 our statutory obligation is, and that's to fund
24 the BLS training, and then to take a look at what

1 the remaining portion of those monies can be used
2 for at the ALS level.
3 The other caveat is that we have actually just
4 about reached the total amount that's in that
5 account to spend each year. So in the past we had
6 turned back monies to the legislature. Because
7 that pattern was repeated year after year after
8 year, they decided that we probably should be
9 given what we actually spend. We now spend pretty
10 much the 11 million that is in that account. So
11 we have a finite pie that we're working with.
12 That pie is very generous. It needs to be
13 allocated in a fashion that is appropriate to both
14 the statute and to what the system needs in order
15 to continue to provide EMS to New York State.
16 So your comments would be appreciated. And
17 I'm just giving this out as an informational point
18 because I think the meeting would be way too long
19 if we started taking comments at this point.
20 That's the end of my report.
21 MR. FAETH: Okay. Thank you, Dr. McEvoy.
22 DR. KAUFMAN: I know you're not taking
23 comments, but one comment for the record, the Fire
24 Department does, indeed, have paper PCRs which are

1 scannable, and those do require shredding, so it's
2 just a mistaken assumption. I wish we were
3 completely computerized, but we are not.
4 MR. FAETH: Thank you, Dr. Kaufman.
5 Okay. Move the agenda to Peer. Tim.
6 MR. CZAPRANSKI: Thank you. Peer met
7 yesterday, and it's going to bring forth one
8 seconded motion, and this is related to the EMS
9 Memorial. The Bureau received a letter
10 recommending that an individual who died while
11 returning from an EMS shift to home stopped by and
12 rendered aid at an accident site and had an MI and
13 passed away, so that was sent to the Bureau. The
14 Bureau said it did not meet the strict
15 requirements of the Emergency Medical Services
16 Memorial criteria and handed it off to the Peer
17 Committee to say, "Take a look at it."
18 Also in that Emergency Medical Services
19 Memorial criteria is the following statement: "If
20 a nomination is not accepted by EMS, those
21 submitting the nomination may appeal the decision
22 in writing to the New York State EMS Council, who
23 will then review the nomination and make a final
24 decision.

1 So in Peer we met yesterday and got additional
2 information, including a completed application,
3 which the Bureau had not had prior to that, when
4 they made their decision, which helped make it a
5 little bit easier decision for us. So in the
6 criteria that the Peer used, we looked at the
7 statement that said the nominee must have died in
8 the line of duty. "Line of duty" is defined as
9 occurring during a response to an emergency or
10 non-emergency call, or on a standby with an
11 authorized EMS service, including traveling from
12 home to a call or EMS station and returning home
13 from a call. It can also be defined as death
14 resulting from illness or injuries sustained while
15 responding to a call.
16 So we talked about it and sort of said if
17 you're an EMS volunteer and the whistle on your
18 pager goes off and you get in your privately-owned
19 vehicle and drive to the EMS station, pick up an
20 ambulance, handle the call, return the ambulance
21 to the station and get in your vehicle and go
22 home, if something happened, that would qualify.
23 But if you went in to work a shift and were
24 returning from a shift, that maybe would not

1 qualify, so it was a little bit of gray area.
2 After reviewing the additional information
3 supplied by the agencies and over a thousand
4 signatures on a petition, the committee agreed
5 unanimously to recommend this seconded motion to
6 the Council to add Mr. Quigley to the EMS
7 Memorial.
8 So I'll entertain the seconded motion. Are
9 there any questions associated with it? Hearing
10 none, all in favor? Any opposed? Any
11 abstentions? Thank you.
12 Additionally, we talked about sort of
13 redefining that, and the Peer Committee is going
14 to look at recommendations to the Bureau and the
15 definition of the criteria to sort of clear that
16 up.
17 We have a summer meeting scheduled for August
18 13 to do the awards, EMS awards, so remember all
19 your agencies, et cetera, need to get them in and
20 postmarked by August 1st so that we can take care
21 of that on August 13th. We have a very tight time
22 line.
23 Vital signs, if you look at
24 vitalsignsconference.com, again, it's October 15

1 through 18, but vitalsignsconference.com is up and
2 available. There's an electronic brochure
3 available on that website, and rooms are now open
4 for reservations. A hard copy of that will go out
5 next week from the Bureau.
6 We're also looking at pins and posters for EMS
7 recruitment, and we'll continue to work with staff
8 on that.
9 That's the end of the Peer report.
10 MR. FAETH: Thank you, Tim.
11 Okay. We're going to momentarily skip over
12 Evaluation and move the agenda to EMS Systems.
13 Mr. LaMarca.
14 MR. LaMARCA: Systems Committee met yesterday,
15 and the secretary has the attendance. There were
16 no seconded motions to bring forward to today.
17 We did hear two reports initially, one from
18 the Safety Committee, which you'll hear in their
19 own safety report a little later, and we also
20 heard from Ray Serowik, who I've asked to just
21 give you a very brief overview today on a report
22 that he has put together based upon the survey of
23 dispense centers and issue of medical oversight.
24 So, Ray.

1 MR. SEROWIK: Thank you. This is a summary of
2 survey results dealing with the presence of
3 emergency medical dispatch systems in 911
4 communications centers throughout the state. This
5 was the survey that was sent out last year,
6 initially in the springtime, and responses to that
7 survey trickled in for the remainder of the year.
8 We made a number of recurring efforts to bring out
9 responses and, ultimately, that yielded a response
10 rate of 52 percent of the counties in the state
11 responding to this.
12 Questions -- key questions here were, first of
13 all, is there a formal emergency medical dispatch
14 system in use in the 911 center and, secondly, if
15 so, is there a physician medical direction for
16 that system within the 911 center operation.
17 The responses were that 97 percent of the
18 responding counties indicated that they were,
19 indeed, using an EMD system, and that there was a
20 predominant system in use in the state and that,
21 in fact, 83 percent of the affirmative responders
22 indicated that they were using the medical
23 priority system. That is obviously far and away
24 the most commonly used. The second most commonly

1 used, the ABCO system, accounted for just over 10
2 percent of those. And then the other two systems
3 each about 3-1/2 percent.
4 Of those respondents indicating that they were
5 using EMD, 93 percent indicated that they had
6 medical direction for that system, which is
7 obviously as it should be. The disturbing
8 converse to that, of course, is 7 percent
9 apparently are practicing EMD without the benefit
10 of medical direction.
11 Conclusions were, first of all, we have to
12 admit that the sample may not be representative of
13 the whole state because, basically, it was the
14 choir that responded to this. Those people that
15 had the feeling that they were doing the right
16 thing and were proud to say so were very quick to
17 do so. And that those who utilize -- who do not
18 utilize EMD might be naturally less responsive to
19 an EMS-driven survey. So a reasonable conclusion
20 might be that the majority of the non-respondent
21 counties may well not be using a formalized EMD
22 system.
23 The vast majority of those utilizing EMD
24 system do so appropriately under physician medical

1 direction, but it's concerning that any of those
2 using EMD do so without medical direction, as the
3 EMD systems themselves generally require it. Lack
4 of physician medical direction also implies that
5 there may be lack of an organized quality
6 improvement process over that EMD system.
7 Recommendations from the proceeding from this
8 is -- are that the SEMAC take affirmative steps to
9 encourage and assist physician medical direction
10 for EMS dispatch centers and their EMD programs;
11 that local and regional EMS QI systems encompass
12 EMS dispatch where possible, and that internal QI
13 within dispatch centers be encouraged and
14 supported by their companion EMS systems. Also
15 that SEMSCO take affirmative steps to promote the
16 use of EMD by all centers responsible for EMS
17 call-taking and dispatching in the state,
18 including an exploration of possible funding
19 assistance for EMD education -- sorry, Mike -- and
20 that there be continued efforts to form ongoing
21 relationships between EMS and 911 dispatch
22 entities on both the state and local levels. Any
23 questions?
24 MR. FAETH: Any questions for Mr. Serowik?

1 Thank you.
2 MR. LaMARCA: We had some documents that are
3 looking at moving past the state-wide wireless
4 network and moving to interpretability, and we'll
5 probably hear from them at our next meeting.
6 Tim Soto stopped in and gave a very brief
7 chronological overview on the progress of state
8 advisories dealing with the H1N1 flu and sequence
9 of events in late April into June and some
10 recommendations there.
11 We -- I should probably finish off Mike McEvoy
12 did, indeed, entertain us with his "draft" budget,
13 but we let him escape.
14 The other issues that came up, really, were
15 the staff report, we have three current appeals
16 through Article 30 actions in the City of Utica,
17 the North Area Volunteer Ambulance Corps, the
18 Niagara Memorial Hospital. They're all with the
19 Bureau of Adjudication, and we probably will more
20 than likely see them in September.
21 There are three new municipal state line
22 declarations, the Albany County Sheriff's
23 Department for an ambulance, the City of White
24 Plains for ALS first response, and the Berkshire

1 Fire District for ambulance service.
2 Something that Lee has mentioned in the past
3 meetings and reiterated yesterday to us is that
4 there are a number of potential issues with
5 billing by ambulance services under the Medicaid
6 guidelines and perhaps the Medicare guidelines,
7 and that she's having an ongoing active discussion
8 with the Office of Medicaid Management and the
9 Inspector General's Office. And there are some
10 very disturbing, you know, things that are being
11 uncovered. She is certainly acting as an advocate
12 for us in talking to the Department to ask them to
13 help us educationally. There will be some
14 correspondence to go out.
15 They are looking at, you know, stay of any
16 enforcement so the penalties will be held until
17 later in the year if services do not acquiesce to
18 the regulations. But her words thus are really
19 that, you know, there is the likelihood that
20 somebody will go to jail if they don't wind up
21 stepping up and making sure things are being done
22 properly. So just as a word of caution, everybody
23 should really, particularly those services that
24 are using an in-house billing service, really make

1 sure that you are doting your i's and crossing
2 your t's, but expect to hear more from her on
3 that. Ed, you wanted --
4 MR. WRONSKI: Yeah. Some of the details I
5 can't give you, but I can tell you the positive
6 thing. Lee worked this out that the Inspector
7 General's Office and Medicaid has been willing to
8 work with us, and they agree that there needs to
9 be some education. But, at the same time, anyone
10 who bills for services is supposed to know what
11 the rules are when you bill for services. But we
12 are working with them. But in the future, really,
13 there will be no forgiveness. And I cannot say
14 that there will be forgiveness for everything now,
15 depending on what they find in their own
16 investigations, but we are working with them on
17 this process.
18 One of the things I would underline for -- and
19 we brought this up to services who have been
20 delinquent before. We, on a regular basis, have
21 ambulance services who fail to recertify every two
22 years for their license, their ambulance license.
23 During the period of time where they haven't
24 recertified past the deadline, they are not a

1 licensed ambulance service in the State of New
2 York by law. They still operate. But some of
3 those ambulance services have gone to billing and
4 have billed organizations like Medicare and
5 Medicaid. During any investigation of an IG, if
6 an ambulance service was not certified -- this is
7 recertified -- during that period of time, they
8 will have to pay back all of the bills that they
9 were reimbursed for during the period of time that
10 they were delinquent in putting in their
11 application.
12 So, you know, I asked the regions and the
13 associations here to make sure that that one
14 piece, don't take lightly your recertification
15 every two years. Make sure your application is in
16 with the Department. You know, if we haven't
17 acted on it, we have it in-house and we know when
18 it was received, and that fulfills the
19 requirements. But if you haven't sent it to us,
20 you're considered a non-recognized ambulance
21 service in the state until you recertify. And if
22 you happen to be billing, then it becomes even
23 more serious and you'll owe funding back to the
24 organizations.

1 But other issues and how they need to be
2 understood by ambulance services of Medicare and
3 Medicaid are both your responsibility, but we will
4 certainly share educational materials with you as
5 they become available.
6 MR. LaMARCA: Thank you. Lee went on to
7 report on EMS for children, and one of the issues
8 that's been the publishing of the list, which she
9 did include, on the pediatric equipment for
10 ambulances, and many of our ambulances and first
11 response vehicles have most of this equipment and
12 some have upgraded to it. They are looking at
13 encouraging ABCs to update their equipment specs
14 to meet the criteria suggested here. And she did
15 point out, though, that in the future these items
16 will probably have to be codified and be part of
17 our review process.
18 She did report on the NEMSIS Technical Center
19 visit that they had related to the governor's
20 traffic safety committee grant, and she did also
21 include in there some selected reading materials
22 of which we've heard some of the policies already.
23 And that's the report.
24 MR. FAETH: Thank you, Mr. LaMarco. Any

1 questions for Andy? Seeing none, we're going to
2 move the agenda to Evaluation. Mr. Delagi.
3 MR. DELAGI: Thanks. Actually, it occurs to
4 me to ask one question of Mr. LaMarca before I
5 start. Just for planning purposes related to our
6 meeting schedules, is it reasonable to believe we
7 will actually have three appeals in September?
8 MR. LaMARCA: From what we had indicated, yes,
9 it looks like we'll probably be dealing three.
10 MR. DELAGI: We may want to cancel everything
11 else.
12 MR. LaMARCA: Well, just to follow up on that,
13 yeah, Lee did voice her concern about trying to
14 get it done within the constraints of a normal
15 meeting, and we may have to put together a special
16 meeting or some other arrangements, but it would
17 not be covered within the one-hour window of
18 opportunity we have for the EMS meeting. And with
19 any luck it will be a new chair of Systems because
20 somebody else will be vetted. Thank you.
21 MR. DELAGI: The Evaluation Committee met
22 yesterday. The staff has the attendance, and
23 there are no seconded motions to come forward
24 today.

1 Bureau staff reported that the GTSC grant,
2 year one, to evaluate the current systems in place
3 in preparation for migration to an electronic
4 reporting platform state-wide is progressing
5 according to expectations. Our Evaluation
6 Committee is currently working with the Bureau on
7 developing Version 6 of the New York State PCR to
8 include required data elements above what we
9 currently collect on Version 5 to meet the Nexis
10 requirements.
11 As it relates to whether or not New York is or
12 is not a NEMSIS compliant state, we can report
13 that New York State has a verbal agreement with
14 NEMSIS Compliance and, therefore, we, as a state,
15 have technically signed on. There are several
16 processes underway to achieve NEMSIS compliance at
17 the state, the regional and the local levels. And
18 along that line the committee is aware of and
19 certainly does appreciate Dr. Cooper's letter on
20 behalf of EMSC transmitting their vote to endorse
21 the decision to pursue NEMSIS compliance, and we
22 certainly support that endorsement.
23 We had a few guests in attendance with us
24 yesterday that we invited in to address some

1 issues, real or perceived, with regard to
2 information sharing between hospitals and EMS
3 providers. Mary Ellen Hennessey and Ruth Lesley,
4 the director and associate director respectively
5 of the Department's Division of Certification and
6 Surveillance, spent some time with us just to wax
7 out some of the issues that we had. They gave us
8 some insight as to hospitals' perceptions and
9 realities with regard to information sharing, the
10 issues of confidentiality and how we can get
11 beyond that. And, obviously, our goal is to
12 create a uniform hospital-to-EMS feedback system
13 on patient follow-up data, and we know that we've
14 been struggling with this for quite some time, and
15 we know that across the state there are varying
16 degrees of levels of participation between
17 hospitals and EMS agencies. And we just want to
18 try to influence that to the degree that we can,
19 because, as you'll hear in a minute, follow-up
20 data and outcome data is going to become very,
21 very important to systems evaluation.
22 So just a couple of summary bullets from that
23 discussion. We know that Article 28 requires
24 hospitals to provide quality improvement

information, and we know that Article 30 and, in fact, the biannual ambulance recertification process both require EMS agencies to perform quality improvement activities. There really is a markedly inconsistent approach across New York State and in many cases a disconnect between hospitals and EMS for data sharing. As I mentioned, this becomes particularly timely as we learn, through the American Ambulance Association, that as they seek to increase Medicare reimbursement for ambulance services, any increases in funding for transportation and care will be tied to a robust quality reporting requirement.

It's also timely because current stroke center designations and future STEMI center regulations will require information sharing with regard to follow-up information on the patients that EMS brings into institutions. During our discussion we reached agreement that we are actually part of the healthcare team and the continuum of care. And that's no surprise to anybody sitting around the table, but what we're able to do is get it on the record that hospitals should not be hiding

behind the HIPAA shield because we are part of that continuum of care. And, likewise, we made it very, very clear that we're only interested in patient follow-up data on the patients we bring in and not interested in a hospital's internal QI activities of its own treatment of those patients and, hopefully, that will go a long way in addressing the situation.

We agreed that we need an Article 28 and Article 30 collaborative agreement, and we will be seeking Council's opinion as to what is required to be done and what can be done in accordance with the laws that control hospitals and EMS providers.

We agree that we typically in EMS measure structure and process, but we desperately need outcome follow-up data to review our quality of care. And that sentiment expressed by us was certainly agreed to by the folks representing the hospitals, and that was very, very encouraging to hear.

We also agreed that we would be splitting this into two separate processes and two separate pathways as they are markedly different. The first one really will address the general

day-to-day EMSC QI initiatives, and the second process would be the full-blown IRB-approved research-oriented outcome studies that many systems and many agencies do.

Pathways are very, very different. The ability for folks to go into a hospital and access charts and collect specific data points is very, very different than an emergency department or a hospital administration providing follow-up data on patients that were admitted or discharged from the hospital.

We'll also be bringing the hospital's associations into this partnership to ensure their buy-in, and we left with a work item that the Department of Health through Ms. Hennessey and Ms. Lesley will be actually creating -- drafting a letter for our review by July so our committee can provide some input in August and have the final draft prior to the September meeting. This is a letter that will go out from the Department of Health to hospitals reinforcing the sort of continuum care approach and that we are actually privileged to have that follow-up information.

Moving on to something else that we've been

working on, we were pursuing a possible partnership with the STAC to help provide admission, discharge or transfer disposition information on patients that were flown to trauma centers in a project that we collaborated on with Air Medical TAG in the recent past. And we learned that while the trauma database is rich with information, it's not contemporary enough to capture the substantive patients that we were looking for, so we'll be talking with Dr. Funk and her committee to see if this is something worth pursuing through another area of data collection or if it's something that we just may abort.

Much like other committees that you've heard about today, we began discussing the issue of physician or mid level practitioner medical direction from an evaluation perspective and, as other committees have experienced, we've had multiple opinions and experiences, and there will be more on that to follow.

The last project that we've been working on is the New York ACEP report card in partnership with New York ACEP as it relates to emergency care in New York State and the specific New York State

1 data points that we had agreed to look at. I'm
2 going to turn the mic over to Dr. Kaufman to give
3 us a report on the very comprehensive work that he
4 had done.
5 DR. KAUFMAN: The American College of
6 Emergency Physicians, ACEP, put forth a report
7 card entitled "The National Report Card on the
8 State of Emergency Medicine, Evaluating the
9 Emergency Care Environment State by State, 2009
10 Edition." This was published in January of this
11 year, similar to the report card they put out in
12 2006.
13 The Evaluation Committee was task'd in
14 reviewing the report card and creating discussions
15 to allow us to improve our EMS system with
16 discussions of these metrics. The Evaluation
17 Committee reviewed the 120 -- I believe 122 -- 116
18 -- excuse me -- metrics in the 2009 report card,
19 and we chose 22 to review in more depth, and we
20 did at this meeting. I'm sorry we don't have
21 hand-outs, but there were some changes that were
22 made yesterday, so we decided to project the
23 report here for you today.
24 First I will show that there's a grade given

1 to each state within five categories, and here you
2 can see how New York State ranks compared to the
3 nation as a whole. The New York State grade is on
4 the right. There are two categories that we felt
5 were more pertinent to the EMS system, those being
6 the quality and patient safety environment, which
7 New York received a grade of A minus, and our rank
8 was 12 out of the 50 states, and the disaster
9 preparedness, where New York also received a grade
10 of A minus and ranked 6th out of the 50 states in
11 the metrics they used. Overall, New York received
12 a grade of C for the weighted average of all the
13 categories.
14 So we -- the Evaluation Committee discussed 22
15 of these metrics and will e-mail the report. But
16 for discussion today we will just choose a couple
17 to discuss.
18 What we did for each metric that was chosen
19 was first to write what the metric was as well as
20 the numeric value given to that metric by the
21 ACEP. Secondly, we looked at the data itself,
22 where the data was extracted from, and gave an
23 interpretation of the accuracy of that data as it
24 relates to the EMS system in New York. So this is

1 not necessarily saying we did good or bad but
2 whether the data that they extracted was
3 appropriate or not as far as EMS. So here we'll
4 just discuss two of the data points, that being
5 metric number 6, funding for quality improvement
6 within the EMS system. The report gave a grade of
7 yes, so we got full credit for that category. We
8 reported the accuracy of that data as fair
9 because, while we felt that there is, indeed,
10 funding for quality improvement within the EMS
11 system in New York, it's not as much as we would
12 like it to be and may be insufficient for the
13 quality improvement efforts we'd like to make.
14 And our recommendation, therefore, was to continue
15 to explore the acquisition of state-wide EPCR data
16 using electronic PCI, which should help improve
17 the quality improvement efforts. However, it
18 would certainly require a lot of funding. In
19 addition to continue to work collaboratively
20 within the Department of Health and directly with
21 the hospitals, as Mr. Delagi just mentioned, to
22 ensure bi-directional data sharing.
23 And just as an example of another metric,
24 metric number 8, adverse event reporting required,

1 again, New York State received full credit for
2 this. The answer was yes. We felt this was poor
3 in the data accuracy as far as the EMS system is
4 concerned because, while we did get a yes, it was
5 really applicable to the hospitals, and there is
6 not currently adverse event reporting mandated for
7 the EMS system. However, as you'll see in the
8 recommendations, the safety TAG has developed
9 reporting requirements that are soon to be
10 implemented, so we are on board with that and did
11 receive full credit.
12 I won't go through all the metrics, but we'll
13 certainly e-mail this around to all the council
14 members and would be glad to have further
15 discussion and hope that these points spark
16 further discussion to improve our system.
17 MR. DELAGI: Just to conclude the report, I
18 did want to just very quickly thank the program
19 agency directors and the REMSCOs who did respond
20 to our requests for information. As we pursue
21 this partnership with hospitals, it's very
22 important for us to provide information to them as
23 exactly what we're looking for from regional
24 levels in terms of follow-up data so that they

1 have a very clear picture of what the expectations
2 are to bring back to the hospital consortium, so
3 thank you very much. And that concludes the
4 report.
5 MR. FAETH: Thank you, Mr. Delagi,
6 Dr. Kaufman. Any questions for Evaluation? Okay.
7 Seeing none, move the agenda to Legislative.
8 Mr. Lewis.
9 MR. LEWIS: Thank you, Mr. Chairman. Our
10 meeting was held yesterday at 4:00, and the
11 attendance was shared with the secretary.
12 While I stop short of saying nothing is going
13 on in Albany right now, and there is probably a
14 picnic lunch in front of the capital, there are
15 about 150 various bills out there that have been
16 introduced by members of the Senate and the
17 Assembly, none of which we chose -- only one of
18 which we chose to take action on yesterday at our
19 meeting, and it comes before you as a seconded
20 motion. It's a source testing bill. The number
21 is Senate 3293 and Assembly 7610. It's titled
22 "Makes Provisions Related to HIV Testing,
23 Including Consent for Such Testing, Required
24 Offering of Such Testing, and Confidentiality and

1 Disclosure." You see that in front of you on the
2 screen. We believe this bill needs to be pushed
3 forward to the Commissioner, and we're hoping that
4 he will embrace it. It's being brought to you as
5 a seconded motion on the table today.
6 MR. FAETH: Okay, seconded motion. As stated,
7 we don't need a roll call for this. By a show of
8 hands -- I'm sorry. Any questions regarding this?
9 Seeing none, a show of hands, all in support? All
10 those opposed? Any abstentions? Motion is so
11 moved.
12 MR. LEWIS: Thank you.
13 There was a concern expressed of some of the
14 legislation that's out there that -- in
15 particular, that there's legislation recommending
16 adding more hours to EMT courses for training for
17 the physically and mentally impaired individuals.
18 I caution us to be very cognizant that we have
19 been challenged on the length of EMT courses as
20 they are today. And lengthening them, I think,
21 will create more problems with recruitment and
22 retention, so stay tuned. We'll be evaluating
23 those types of pieces of legislation that extend
24 EMT training courses and probably report back to

1 you.
2 MR. MURPHY: These are impaired EMTs?
3 MR. LEWIS: Yes, sir.
4 MR. FAETH: Thank you, Mr. Lewis. Any
5 questions for Legislative? Seeing none, that
6 concludes our committee reports, but I do have two
7 TAGs. I have the Safety TAG. Warren.
8 MR. DARBY: Safety TAG met yesterday, also, at
9 4:00 p.m., and we had 17 in attendance.
10 The first item of business was that the Bureau
11 provided us with a draft we've been working on for
12 reportable incidents. Pursuant to the 800.21 they
13 have come up with a draft of the DOH 4461 form.
14 And our TAG went through and made the final
15 corrections with the staff, and we had a unanimous
16 vote to move it to production. Does the TAG need
17 to bring that kind of motion to the Council is my
18 question.
19 MR. WRONSKI: Well, if it's a question, we'll
20 sure bring it forward.
21 MR. DARBY: Then we bring a seconded motion
22 from a Safety TAG to move forward with the DOH
23 4461 draft form of reportable incidents.
24 MR. FAETH: Okay. Any question for Mr. Darby

1 on that? Seeing none, all those in favor, show of
2 hands. All those opposed? Any abstentions? Pass
3 unanimously.
4 MR. DARBY: We also talked about the Vital
5 Signs Conference that's just come out with the
6 program, and we'd like to commend the Bureau and
7 specifically Donna Johnson, who kept a safety
8 message throughout the vital signs which we've
9 been asking for. And this particular conference
10 coming up in Rochester, the opening session
11 itself, "The EMS Under Fire" is the subject of
12 that. The issue talks about prevention all the
13 way from prevention to tactics of taking care of
14 yourself and your partner at those kinds of
15 scenes, and we applaud that.
16 Then there's a session during the course of
17 the conference, "Street Smart EMT, Recognizing
18 Signs and Symptoms of Dangers and What to Do When
19 You See or Understand There is a Danger At That
20 Scene." So we applaud that, and we will continue
21 to work with Vital Signs in every upcoming one to
22 see to it that there's a safety message.
23 The TAG worked -- continued to work on the
24 white paper. We're trying to provide by 2010 a

1 New York State EMS Safety Best Practices white
2 paper around all of the safety practices we've
3 been able to identify, and we have received a
4 number of additional points to that. We're up to
5 two pages of bullet points on that.
6 Over the summer we're going to be having a
7 conference call over this issue and, hopefully,
8 have some wordsmithing done for our September TAG
9 meeting.
10 Within that there is also some safety
11 recommendations that are coming from the Education
12 and Training Committee with respect to how to work
13 in the safety message throughout the curricula
14 that we require for our EMS educators to give to
15 their students. We have talked about the issue of
16 trying to come up with a safety culture throughout
17 the state. We spoke at this TAG meeting about
18 bringing it down to the regional level, and there
19 are some regions that have put on some safety
20 seminars or some workshops when they have such,
21 and if they're successful, we'd like to know about
22 that and see if maybe it would be available to
23 move to other regions so we can help promote the
24 safety from the region up.

1 For instance, in the -- in my area we have the
2 fun CMEs, and we put a safety page on that
3 particular website now. North Country has red
4 lights and sirens posted there. Paul Bishop's
5 sessioned it from last Vital Signs, 2008 Vital
6 Signs, creating a safety culture. That whole
7 program is getting posted in the near future on
8 that site. And any way we can get another safety
9 message out to our community, we'd like to do
10 that.
11 At the Systems Committee I received the letter
12 that our new Acting Deputy Director, Lee Burns,
13 put out to a Dr. Brian Maguire in support of a
14 program. Dr. Maguire is with the University of
15 Maryland Department of Emergency Health Services.
16 He's also a professor there. He's working on a
17 research project. They have a grant proposal in
18 to NIH, National Institutes of Health, and he's
19 looking for -- looking at EMS occupational
20 injuries and developing interventions that are
21 intended to reduce the risk that cause those
22 injuries. Lee put a nice letter of support back
23 from the Bureau and in the letter pointed out that
24 SEMSCO has got a TAG that's working on this

1 particular issue of safety, and we are going to
2 send a letter to Dr. McGuire offering our support.
3 What he's going to want to do is open up a
4 survey to all of New York State's EMTs. And there
5 is some interesting parts of this research project
6 that we will be reporting on, I'm sure, in the
7 near future. I'm going to attempt to get
8 Mr. Maguire to the September TAG meeting so we can
9 be directly involved right from the onset.
10 We also had a group from central New York work
11 on a safer ergonomic and functional layout of an
12 ambulance. The whole issue of being strapped in
13 and still being able to do EMS in the back of that
14 rig has always been something we have struggled
15 with.
16 The northeastern rescue vehicles up in
17 Syracuse and TLC Medical Transportation Services
18 had brainstorming sessions for 40 to 50 hours of
19 what can we do to make that safer, and a Canadian
20 ambulance builder, Demers, up in Quebec has built
21 a model under that brainstorming session. That
22 model will be at the fire chief's meeting next
23 weekend over at Turning Stone.
24 And we were offered to bring it over here, but

1 it was such short notice we made a commitment to
2 bring it here in September, just for our council
3 to take a look at things that may be able to be
4 done to keep a safer environment in the back for
5 our people and look for more suggestions. Here's
6 a company that's willing to try to prototype and
7 get it out there, so we'll have that here for
8 September.
9 We talked about safety is not a glamourous
10 topic. It is not. It doesn't sell tickets. But
11 it is something that we have to just keep pushing
12 and keep talking about and we, as a TAG, will do
13 that.
14 We thank you for your support.
15 MR. FAETH: Thank you, Mr. Darby. Any
16 questions for Warren?
17 Before I move to the Diversity TAG, one quick
18 note I forgot to mention earlier. Anyone who
19 needs their parking ticket validated, please see
20 Ms. Donna Johnson. She's standing up over there.
21 That will cover your expenses for the parking
22 today. So she's available.
23 I'll pass this over to Mr. Czapranski.
24 MR. CZAPRANSKI: The Diversity TAG met

1 yesterday at 4:00 as well, and we had no seconded
2 motions or anything to bring forward.
3 Our discussions mainly focused on a couple of
4 things, measuring or taking a snapshot of where we
5 are in REMACs and REMSCOs around the state today
6 by geography related to diversity. Second was a
7 discussion about a policy for REMACs and councils
8 asking them simply to create a diversity policy
9 seemed a little inadequate unless we demonstrate
10 some templates that may be of use to them, so the
11 Bureau of EMS is going to work and look and see
12 what the State has as templates that may be
13 utilized to help councils on REMACs create a
14 policy on diversity.
15 Then the third thing we talked about was
16 really creating an annual report probably tied
17 into one of the deliverables that says, you know,
18 the councils and the REMACs have to report on how
19 they meet Article 30 and how they would meet their
20 diversity policy. So those are three discussions
21 we're having with the Bureau of EMS to work on
22 those issues.
23 One of the other discussion points we had was
24 that typically a lot of public safety, police,

1 fire, and in many cases EMS, are civil service
2 employees, and one of the issues is that many of
3 those civil service employees have a family member
4 who is engaged in civil service or in a group in a
5 family where they understood the civil service
6 process. In many of the minority communities that
7 may not be the case and there's a misunderstanding
8 of what civil service is, or they don't understand
9 it at all.
10 So the focus is how do we reach out in the
11 high school educational level on career days and
12 otherwise to help folks understand the civil
13 service process so that they're not afraid of it
14 so that they can maybe get into a service civil
15 position. Again, recruitment and retention is
16 important and diversity is important, but we need
17 to bring it in at the rank and file first and then
18 allow it to develop from there. So that's it from
19 the Diversity TAG.
20 MR. FAETH: Thank you, Tim.
21 Any questions? Seeing none --
22 MR. WRONSKI: I would just again reiterate we
23 welcome membership in Diversity TAG right now. It
24 has about three members, four members, so not very

1 diverse, so please see Tim or notify Donna Johnson
2 and we'll get you on that committee.
3 MR. FAETH: Thank you, Ed.
4 Okay. I think we're moving right along here.
5 Do we have any unfinished business for the
6 Council? Anybody? Mr. Zeek.
7 MR. ZEEK: I was just thinking that we should
8 recognize the contributions of our longest-sitting
9 member and the staying power of -- he finally has
10 been able to relinquish his seat, Mr. Mike Quinn.
11 Maybe he would have some parting words for us.
12 MR. FAETH: I believe this month was 20 years
13 on the Council.
14 MR. QUINN: I don't want to sit. I can still
15 stand, in spite of everything.
16 Twenty years ago this month I was initially
17 appointed to the Council by then director of the
18 Bureau and -- Dr. Axelrod, who, unfortunately, had
19 an unfortunate demise sometime later.
20 At the time I was appointed, there was a lot
21 of differences in Article 30 than there is today.
22 At the time I was appointed, you could serve two
23 consecutive two-year terms and then you were out.
24 During that four years that I was on, due to a

1 lot of problems, we had a lot of problems with
2 staffing and so forth, a consortium of concerned
3 persons was formed to redo Article 30. At the
4 time that got done, a few things we missed there,
5 but I think we did a pretty good job at that time.
6 And in that process we made the duration four
7 two-year terms, and I just fell right on the seam
8 of that at the time.
9 I served out that total of eight years. My
10 replacement was a fellow named Dick Beech. Dick
11 named me his alternate, so I stayed on as his
12 alternate. Three years later Dick had a little
13 personal problem and resigned, and I got put back
14 on again.
15 My term really expired a year and a half ago.
16 However, due to unforeseen circumstances -- or
17 foreseen, I'm not sure which -- I was still on
18 until my successor, Mr. Reid, got his appointment.
19 Unfortunately, Mr. Reid told me that he was going
20 to put me down as his alternate, so you may still
21 have to put up with me for a while.
22 But there has been a lot of advances since the
23 time I got on until now. We're still not
24 finished. We have a lot of things to do. I'm not

1 really satisfied that New York is in the forefront
2 of on-the-road EMS. I think we need some things
3 done. We need a little more initiative, but let's
4 keep on working on it.
5 And I want to thank the staff and all of the
6 members that have served with me over those years
7 on the Council for their participation and
8 friendship, et cetera. Thank you very much.
9 (Applause)
10 MR. FAETH: Thank you.
11 Okay. Unfinished business. I do have an
12 issue I'd like to bring forward. Sorry.
13 Several meetings ago there was a discussion
14 with regards to AEDs. Many here were somewhat
15 shocked that it was --
16 MR. ZEEK: No pun intended.
17 MR. FAETH: Yes, no pun intended -- that there
18 are some ambulances running throughout the state
19 that do not have an AED on them. Since then there
20 has been a lot of discussion going back and forth
21 in several of the committees that it's got to the
22 point now where I'm getting feedback that some
23 people are just getting tired of talking about it.
24 So I am going to make a motion. The motion is

1 that the SEMSCO body recommends to the State to
2 include AEDs in the Part 800 section of state
3 regulations as being standard equipment for all
4 ambulances, all transport ambulances. Do I have a
5 second?
6 DR. KAUFMAN: Second.
7 MR. FAETH: Dr. Kaufman seconded. Discussion?
8 Yes, Mr. Zeek.
9 MR. ZEEK: Does this mean an AED in addition
10 to a cardiac monitor that has AED capability?
11 MR. FAETH: The ability to shock, yes.
12 MR. ZEEK: Do you understand my question?
13 MR. FAETH: Not exactly. Are you saying you
14 have capability for defibrillation?
15 MR. ZEEK: Yes, paramedic ambulance with a
16 cardiac monitor that also has an AED capability on
17 the monitor; that will satisfy your requirements?
18 MR. FAETH: Most definitely.
19 Any further discussion? Yes, Mr. Brandt.
20 MR. BRANDT: Are these intended to be staffed
21 on-duty ambulances, or would there be an allowance
22 for off-duty or reserved-capacity vehicles?
23 MR. FAETH: Anyone that is actively rolling in
24 the system, that if that vehicle goes online, it

1 needs to have an AED on it.
2 MR. BRANDT: If it's on duty, in other words;
3 am I correct in my assumption?
4 MR. FAETH: Yes.
5 MR. BRANDT: Okay.
6 MR. FAETH: Yes, Mr. Blum.
7 MR. BLUM: BLS first response units, those
8 would be included in this or exempted from it?
9 MR. WRONSKI: It's not so much a matter of
10 exemption. We don't have the authority to demand
11 the equipment be carried by BLS first response.
12 What we can certainly recommend as advice is that
13 they carry AEDs if they can, but we don't actually
14 have the authority to do that.
15 MR. BLUM: For certified ELS first response
16 vehicles you can, correct?
17 MR. WRONSKI: There is a -- we actually do not
18 have certified ELS first response vehicles. We do
19 have ambulances and we have ALS first response.
20 What we do with BLS response vehicles is authorize
21 them to carry red lights and sirens through their
22 ambulance service, but there's no equipment
23 requirements for them. That would be a whole
24 another discussion, whether to move in that

1 direction. But right now I know we have no direct
2 authority to -- for BLS first response,
3 non-transporting, to demand certain equipment on
4 the vehicle.
5 MR. BLUM: And then just one follow-up, a
6 phase-in period, you're considering, so it
7 wouldn't be effective immediately? I mean, it
8 would be phased in over some period of time?
9 MR. FAETH: They have been available now for
10 20 years. I think the phasing period has passed,
11 personally, unless there is a different feeling of
12 the body. I see none, no. It's at the point in
13 time in which the State can move on getting out
14 that verbiage.
15 Yes, Mr. Murphy.
16 MR. MURPHY: With reference to EASVs, I
17 believe there is equipment requirements for those
18 vehicles and would we be adding AEDs to those?
19 MR. WRONSKI: It's a good question. What does
20 the group want and how many vehicles do we think
21 these are? I'd have to defer to Lee to give me
22 some data on that and what the actual reality is
23 out in the state.
24 MR. MURPHY: I think what Dan might have been

1 referring to as BLS first response was the ESVs
2 that are first response vehicles.
3 MR. FAETH: Right.
4 MR. MURPHY: They do have equipment
5 requirements and, obviously, when they're in
6 service, should, I think, if we follow the flavor
7 of the chairman's motion, be equipped with AEDs.
8 MR. WRONSKI: Okay. I have no objection to
9 it, and I apologize if I misunderstood that, but
10 if it's a certified vehicle and there is built-in
11 equipment requirements for it, then we can
12 certainly make a recommendation to add that, if
13 you choose.
14 MR. BLUM: I guess just one note. I believe
15 under that EASV regulation there's a provision to
16 exempt certain items of equipment if so approved
17 by the regional council. That can then be
18 submitted to the State for their validation, so
19 those entities that have a hardship with their
20 EASVs could conceivably get an exemption.
21 MR. FAETH: Yes, sir.
22 DR. DAVIDOFF: I would just like to add a word
23 about the possible exemption of EASVs. A lot of
24 people who have EASVs are providing the equipment

1 out of their own budgets. Keep in mind that the
2 reason why we have those vehicles is to provide
3 the first responder ABCs. And, certainly,
4 electricity is very important -- I don't disagree
5 at all -- but to take away the basics because they
6 can't provide that equipment for their own
7 vehicles, we may be doing a disservice to the
8 community, so we may want to consider those
9 personal vehicles maybe not having to spend the
10 money.
11 MR. FAETH: The original verbiage of this is
12 transport ambulance vehicles.
13 Yes, Mike.
14 MR. REID: I'd just like to speak to
15 Mr. Blum's point about a phase-in period. I fully
16 support the concept of having AEDs on our first
17 response vehicles and our ambulances. But I think
18 with any equipment requirement that this body puts
19 in place, there has to be a phase-in time to allow
20 people to budget to purchase the equipment. I
21 would suggest a period of six months.
22 MR. FAETH: With all due respect, personally,
23 I kind of feel that they've had adequate knowledge
24 of the importance of this piece of equipment.

1 This is like oxygen. So for whatever it's worth,
2 it's -- this has just been something that someone
3 has dropped the ball on for quite a while if they
4 don't have it on. We're just formalizing what is
5 standard care at this point. So I'm opposed to
6 that, but if the body has a difference of opinion,
7 please let me hear it. Yes, Mr. Zeek.
8 MR. ZEEK: I'm considering making a motion to
9 table pending clarification of all the questions
10 that have been raised here. I don't want to
11 appear to be in opposition to this, and I'm
12 certainly not, but it seems to me that it would be
13 difficult to flush out all this stuff here at the
14 end of this meeting, so I would make a motion to
15 table until the next meeting pending clarification
16 of the questions raised here.
17 MR. LEWIS: Second the motion.
18 MR. ZEEK: And you have to vote on that now.
19 MR. FAETH: Mr. Lewis is seconding the motion.
20 All in favor? Can I have a count of the hands?
21 Please raise your hands high if you support that
22 motion. Roll call vote.
23 MS. JOHNSON: Unofficial roll call, just so we
24 can get a count. This is the motion to table.

1 (Whereupon, a roll call vote taken.)
2 MS. JOHNSON: 14 yes and 10 no.
3 MR. FAETH: Okay. Motion to table passes.
4 MR. MASTRIANNI: I know I can't make a motion
5 or any of that, but I thought at one point we had
6 had a discussion that if there was going to be
7 equipment mandates or that kind of thing that we
8 were going to be referring those issues to the
9 Systems Committee to -- as the point where one --
10 where a committee would be able to take a look at
11 its implication on the system.
12 MR. WRONSKI: Yeah. Actually, this has
13 already been done. If you remember, we had a
14 couple of meetings where information was brought
15 forward, a survey was done, we determined the
16 impact of AEDs in the system, who had them and who
17 didn't have them, and we actually went over that.
18 What we didn't finalize is -- of course, I
19 indicated that the Department wants to add a
20 language that says all ambulance services will
21 carry a defibrillator device and add it to Part
22 800, so we fully intend to move that forward. And
23 you'll ultimately have to vote on some language,
24 but there's some additional language here and

1 questions regarding EASVs, et cetera, or
2 implementation period of six months or not, which
3 has been put on the table.
4 But we actually took a look at this quite a
5 while and discussed it, so I don't think in this
6 case we need to send it back to subcommittee. I
7 think we need to answer those questions and then
8 come to a conclusion of what we want to do.
9 MR. MASTRIANNI: Okay.
10 MR. FAETH: Thank you. Yes, Mr. Reisner.
11 MR. REISNER: Could we ask the Department,
12 since they've been giving this issue consideration
13 for some time, to draft the proposed language that
14 would be the amendment to 800 so we'll have
15 something concrete taking into account the issues
16 that have been raised today.
17 MR. WRONSKI: Yeah, I have language, and I can
18 formalize that for the meeting, just give it to
19 you. I've recommended to my staff language.
20 What this body is going to have to think about
21 is how broad will it be? My language strictly was
22 focused on ALS first response and transporting
23 ambulance services. And it would also require
24 that any ambulance that is responding -- any

1 ambulance that transports a patient must have the
2 ability to defibrillate that patient, and so that
3 would require, if you roll an ambulance, there
4 needs to be a defibrillator available if you're
5 going to have a patient that you're going to
6 respond to.
7 The additional piece of EASVs, et cetera,
8 needs to be thought about between now and
9 September, and for any modification what I'll ask
10 the staff to do is kick around a couple of
11 modifications to language, and I'll share that
12 with the committee chair, Don Faeth, and Dr. Henry
13 and just ask for their comments, and you can see
14 variations of language. But it will be pretty
15 simple, you know. If you've got a patient in your
16 rig or you are ALS first response first on the
17 scene, you need to be able to defibrillate.
18 That's my view, and I think it's yours.
19 MR. CZAPRANSKI: Mr. Wronski, I'd ask the
20 Bureau to also look at the Part 18 requirements
21 where a BLS ambulance may serve onsite at a Part
22 18 event of not over 5,000 people yet not be a
23 transport ambulance, yet, in my opinion, should
24 still have defibrillation capability.

1 MR. LEWIS: Mr. Chair.
2 MR. FAETH: Yes, Mr. Lewis.
3 MR. LEWIS: Maybe if Mr. Wronski could share
4 with us the extent of time it may take to add
5 defibrillators to Part 800, it probably is a
6 process that will not happen overnight.
7 MR. WRONSKI: I have to tell you my personal
8 recommendation is to ask the commission for an
9 emergency regulation. But I wouldn't do that
10 without knowing that I had your support.
11 I think we clearly put it on the record the
12 last couple of meetings that we wanted to do this
13 and supported it. I mean, there was some question
14 of how much of an impact that might be on some
15 segments of the EMS system and, really, there was
16 not much, as we could judge.
17 The addition of the ESAVs, et cetera, might
18 have a different impact. It's been brought out,
19 and we have to look at that and how we might
20 implement that.
21 There is, as I was reminded, and I, rethinking
22 my memory of the ESAVs, there is a specific
23 section of the law that does allow for waivers
24 of equipment requirements if the service provides

1 a plan to the regional council that discusses how
2 they are going to provide appropriate personnel
3 and equipment to get to a scene.
4 But put all that aside and keep this simple,
5 all right? At the very least, transporting
6 equipment -- an ambulance and an ALS first
7 response, in my view, should have an AED or a
8 defibrillator available. I don't really hear any
9 valid arguments any more across the country that
10 they shouldn't, so once we vote on something like
11 that, I'll push very hard to see if I can get it
12 implemented.
13 MR. LEWIS: I believe without hesitation I can
14 say that every ambulance responding in a 911
15 system in the State of New York has a
16 defibrillator. I think I can safely say that. I
17 think there are some that are non-emergent
18 transport services that may not. And I can't
19 disagree that clinically they should have, but I
20 think there needs to be an implementation period,
21 as we have talked before. It is a fiscal cost to
22 some services. Do we want to shut them down
23 because of that? I don't believe so, because they
24 are providing quality services and needed services

1 to their community.
2 So I think -- again, I will say that ONION
3 supports every ambulance responding in the 911
4 system must have a defibrillator on board. We
5 just have concerns about those who are not part of
6 the 911 system and when would they implement that.
7 MR. FAETH: With all due respect, Mr. Lewis,
8 if they don't have a defibrillator, they're not
9 providing quality services. All right. That's my
10 personal opinion. Okay.
11 I do have another issue. Sorry.
12 Back in September '07 Mr. Zeek was the chair
13 of a TAG that had 16 members, most of them in this
14 body, that worked very hard on acquiring
15 information, opinions, received some outside
16 assistance from other systems with regard to
17 moving towards licensure for pre-hospital
18 providers. At that time -- and I know it's been
19 approaching that two-year mark here -- I don't
20 believe much has been moved since then.
21 Your report recommended that some type of task
22 force be put together, and that would start a
23 communication with the Department of Education --
24 MR. ZEEK: That's correct.

1 MR. FAETH: -- with regards to seeing the
2 viability of looking at licensure, what they're
3 willing to license, if it's just paramedics or if
4 it would be paramedics and EMTs, and also looking
5 at permanent certification and then seeing whether
6 or not there's even an open door for going in this
7 path.
8 The other main recommendation had to do with
9 putting out a survey to the majority of the
10 providers out in the field today to get their
11 feedback and understanding of how much they desire
12 to move to one of these other forms of
13 certification, licensure. So I would task, I
14 guess, Evaluation with, if you would, to put
15 together the survey, and we'll talk about how that
16 would be distributed. And as far as the task
17 force, I'd like you to let me know if you'd be
18 interested in being on that.
19 And I guess, Ed, do you have anything else,
20 any comments on that?
21 MR. WRONSKI: I know the white paper
22 recommended this. I also seem to remember there
23 was -- I don't know that there was absolute
24 consensus by the body back then as to whether or

1 not to move toward licensure but maybe that wasn't
2 clear to me. Certainly, further exploration of it
3 was asked for.
4 I have not moved aggressively towards putting
5 a task force together on this, but what I would
6 suggest as a first step is see if I can arrange a
7 meeting with a couple of us, just with the State
8 education people, just to sit down and talk about
9 it as a preliminary matter and see what roadblocks
10 might be there from their point of view.
11 MR. FAETH: Thank you, Ed.
12 Yes, Mr. LaMarca.
13 MR. LaMARCA: Just as a follow-up, after that
14 TAG that -- Vital Signs we actually had a little
15 survey, and it was pretty apparent from the
16 results of that that if you're going to put
17 another survey out in the field, people need to
18 know exactly what it would mean to be licensed.
19 Ask the question whether they want to be licensed,
20 they'll say yes. Ask the question after they know
21 that you'll have to have an associate's degree or
22 whatever else they have to have, and the answer is
23 very different. So perhaps the first thing would
24 be better to put it out after the discussion with

1 State Ed to get at least some idea of roughly what
2 that would entail so you have an educated answer.
3 MR. FAETH: Definitely agree.
4 Any other comments?
5 MR. ZEEK: No. The white paper did recommend
6 that a task force be set up. It didn't recommend
7 who should own that task force or who should start
8 it, so we kind of wait and see what happened.
9 MR. LaMARCA: Mike Quinn. He's available now.
10 MR. FAETH: I do have another issue, third and
11 last one.
12 MR. LaMARCA: Three wishes.
13 MR. FAETH: My third wish.
14 There has been a lot of feedback to me from
15 providers out in the field that -- and there's
16 been talk here which has gotten kicked around
17 about universal protocols for the State, that
18 there be one set, because many providers work many
19 different systems, and sometimes they find it
20 difficult to maintain the knowledge of the
21 different whims of different regions when, at the
22 end of the day, whether you live out in Montauk
23 Point or you live in Buffalo or you're in
24 California, you're basically made the same way.

1 So the problem apparently exists where different
2 physicians have different likes and dislikes for
3 certain medications, and that seems to be the
4 issue. But when you come right down to it, there
5 is no personal ownership of the EMS system by any
6 physician. The system is for the people that
7 we're treating, and I think that there is more
8 than enough reason for people to be involved.
9 There's been, also, question and discussion
10 about online medical control and, very
11 disturbingly, we find certain regions don't have
12 the availability of that. If you have a universal
13 set of protocols, then somebody from Montauk who
14 is a physician can technically give, you know,
15 direction to somebody from Buffalo if they're the
16 only physician available, as long as they're
17 versed in the protocols.
18 I don't know how comfortable they feel if they
19 don't know the providers, but I want to know what
20 the pleasure of the body is on that. Is that
21 something that this group would like to see more
22 discussion on and some kind of movement towards?
23 MR. REID: Yes.
24 MR. FAETH: Mr. Reid, did you say yes?

1 MR. REID: I think you should pursue it.
2 MR. FAETH: Mr. Zeek.
3 MR. ZEEK: I think it's clearly a sensible
4 thing to do. We have tried on and off over the
5 years to do that and met with a certain amount of
6 resistance from different regions because of the
7 different ways they like to approach things. So
8 if we can somehow overcome that, I think Sharon
9 Schmento made a good presentation with her format
10 for ALS protocols, I think that's probably a good
11 place to start.
12 MR. FAETH: I agree. Anybody else? Mr.
13 Reisner.
14 MR. REISNER: I strongly support the creation
15 of state-wide protocols as long as there's
16 regional allowances for variation for CC's to not
17 be knocked down, to be diminished in what they can
18 do out in the field, especially in those regions
19 where they are the primary ALS providers.
20 MR. DELAGI: I think what we're really trying
21 to accomplish here is to not get so caught up with
22 the difference between a standard of care and
23 practice protocol but rather just to uniformly
24 apply good science and good medicine across the

1 board. And the issue of the provider's level of
2 standing orders versus medical control options is
3 really not part of the discussion. It's really
4 the uniform application of good standard of care
5 principles. We should be treating AMS the same
6 way; we should be treating defib arrest the same
7 way, and so on and so forth.
8 MR. FAETH: Okay. So I guess we'll be putting
9 that to SEMAC?
10 MR. WRONSKI: This is always an issue that can
11 open up lots and lots of discussion, but SEMAC
12 actually is already working on this document and
13 has supported and voted in the past that it wants
14 to have an ALS set of standards that would help
15 uniform care.
16 It doesn't do away with the ability for
17 regions to have modification or variation. So I
18 think it's good to put on the table that the
19 SEMSCO body, which has to be the final approver of
20 these types of things, supports the -- still
21 supports today the idea of a statewide standard.
22 It might be useful to have a show of hands if
23 this is a direction the body as a whole wants to
24 continue to pursue and let the SEMAC know that.

1 MR. FAETH: So the motion is for us to pursue
2 seeking state-wide universal protocols for New
3 York State. All those in favor? All those
4 opposed? Any abstentions? Seeing none, it passes
5 unanimously. Thank you.
6 I believe Mr. Delagi has something he wants to
7 address.
8 MR. DELAGI: Thanks, Mr. Chair. Given the
9 late hour, I just want to kind of plant a seed for
10 what I hope to be future discussion as it relates
11 to the bill that Mr. Lewis referred to, adding
12 hours to EMT training for physical and emotional
13 disabilities. I'm fully aware of the implications
14 of additional training hours on our EMS providers
15 and very aware of the cost associated with that,
16 not only in terms of time but also financially,
17 but I'm not sure that we can ignore the fact that
18 our EMS services are encountering more patients
19 with mental illness. We're seeing more patients
20 with autism spectrum disorder. Witness the RMRDD
21 directive to provide focused training to EMS
22 providers with respect to autism spectrum
23 disorder. We have more regions developing
24 chemical restraint protocols. We have issues with

1 humane physical restraint and positional asphyxia.
2 We have a de-escalating military that are coming
3 back to live in our communities. And from a
4 safety perspective, witness what we just saw in
5 the North Country and in other places where that's
6 happened before. I'm not sure that we can ignore
7 additional training for this type of a
8 circumstance.
9 Our curriculum now collectively probably gives
10 us an hour in behavioral emergencies, and not that
11 we would like a law to be enacted to require us to
12 do this, but perhaps we should be proactive in
13 addressing this ourselves through our Education
14 Committee and other venues.
15 MR. FAETH: Thank you, Mr. Delagi.
16 Any further old business? Yes, Mr. Reisner.
17 MR. REISNER: I know it's late now. I'll try
18 to be quick with this, but I did want to summarize
19 some legislation that was passed in the governor's
20 budget that almost had a very deleterious effect
21 on ambulance services state-wide.
22 The governor's budget put a sales tax on
23 transportation services. The actual language
24 proposed by the governor clearly exempted

1 ambulance services. However, the legislation that
2 was passed that would have been effective on June
3 1st did not include that exemption.
4 So I thank Senator Young and Senator Breslin
5 for their good work with this sales tax
6 department. And we worked diligently and the
7 Friday before June 1st got a sales tax bulletin
8 which made it clear that ambulance services are
9 not -- I repeat -- are not subject to sales tax.
10 MR. FAETH: Okay. Thank you, Mr. Reisner.
11 Any further old business? Going once. Going
12 twice. Any new business? Yes, Mr. Wedge.
13 MR. WEDGE: Forgive the new kid on the block,
14 but in checking my notes, there's one more TAG
15 that I have to discuss that we created yesterday,
16 and that's the TAG to look at the impact of EMTI
17 in the State, how many are there and are they
18 really utilizing those skills or have the
19 opportunity to utilize those skills that they're
20 trained to do.
21 MR. FAETH: Okay. Are you going to be
22 receiving that information from the population, or
23 are you directing that to somebody else?
24 MR. WEDGE: The TAG will decide on how they're

1 going to do that. I have the TAG set up already.
2 MR. FAETH: Okay. If you are a service
3 provider that utilizes MTI, please let Mr. Wedge
4 know how this will impact you if that is
5 eliminated.
6 Any other new business? Any further new
7 business? Do I have a motion?
8 MR. DARBY: I make the motion that we adjourn.
9 MR. FAETH: Motion by Mr. Darby to adjourn.
10 MR. LaMARCA: Second.
11 MR. FAETH: Second by Mr. LaMarca. All those
12 in favor? Anybody opposed?
13 Everybody get home safely. Thank you. See
14 you on September 2nd.
15
16
17
18 * * * 12:41 p.m. * * *
19

1 C E R T I F I C A T E
2
3
4
5 I, Kay Trigilio, a Shorthand Reporter
6 and Notary Public in and for the State of New
7 York, do hereby certify that the foregoing record
8 taken by me is a true and accurate transcript of
9 the same, to the best of my ability and belief.
10
11
12
13 ____________________________
14 Kay Trigilio, Notary Public,
15 State of New York
16
17
18 DATE: July 4, 2009