

Committee of the Central New York Emergency Medical Services Council, Inc.
April 8, 2010 Meeting Minutes

| Name | Title | Present (X) | Status | Representation |
|---------------------|-----------------|-------------|------------|--|
| <i>Members</i> | | | | |
| Butler, David | EMT-B | X | Non-Voting | BLS Provider Cortland |
| Ciaccio, James | MD | X | Voting | Emergency Dept. Physician Community Gen Hospital |
| Clawson, Melissa | RN | | Non-Voting | Emergency Dept. Nurse Tompkins |
| Cooney, Derek | MD | X | Voting | Agency Medical Director-CAVAC, DeWitt, EAVES, NOCA |
| Darby, Warren | EMT-B | X | Non-Voting | REMSCo Chair |
| DiGregorio, Anthony | EMT-P | | Non-Voting | BLS Educator |
| DiRubbo, Mary | MD | | Non-Voting | Auburn Memorial Hospital |
| Fields, Maryann | RN | | Non-Voting | Trauma Center |
| Flynn, Shawn | EMT-CC | X | Non-Voting | BLS Provider Tompkins |
| Flynn, Susan | EMT-P | X | Non-Voting | ALS Provider Tompkins |
| Fullagar, Chris | M.D., FACEP | X | Voting | Emergency Dept. Physician SUNY Upstate Med University Hospital |
| Gascon, Cupid | MD | X | Voting | Emergency Dept. Physician Oswego Hospital |
| Hogue, Troy | EMT-P | | Non-Voting | ALS Provider Onondaga |
| Iannolo, Patsy | MD | X | Voting | |
| Jorolemon, Michael | D.O. | X | Voting | Emergency Dept. Physician Crouse Hospital |
| Koch, Drew | D.O., FACOEP | | Voting | Emergency Dept. Physician Cayuga Medical Ctr. |
| Koenig, Paul | MD | | Voting | Emergency Dept. Physician Auburn Memorial |
| Kowalski, Michael | MD | X | Voting | Emergency Dept. Physician VA Medical Center, Syracuse |
| Kushyk, Donna | PharmD | | Non-Voting | Pharmacy |
| Lagoe, Ron | PhD | | Non-Voting | Hospital Administration |
| Loomis, Bob | EMT-B | | Non-Voting | Dispatch Personnel |
| Mackey, Jennifer | MD | | Non-Voting | Pediatric Emergency Medicine Physician |
| Markham, Joseph | MD | X | Voting | Emergency Dept. Physician St. Joseph's Hospital |
| Merrill, Peggy | EMT-P | | Non-Voting | AIS Provider Cortland |
| Morrison, Jerome | RN, EMT-P | X | Non-Voting | Emergency Dept. Nurse Cortland |
| Olsson, Dan | D.O., FACOEP | X | Voting | Regional Medical Director |
| Perkins, Barb | RN | X | Non-Voting | Emergency Dept. Nurse Cayuga |
| Ramsey, David | RN | X | Non-Voting | Emergency Dept. Nurse Oswego |
| Rathbun, Joseph | EMT-B | | Non-Voting | BLS Provider Oswego |
| Sowles, Donna | EMT-P | | Non-Voting | ALS Provider Cayuga |

| | | | | |
|-----------------------|-----------|---|------------|---|
| Thomson, David | MD | X | Voting | Agency Medical Director - Rural Metro |
| Wallis, Norm | EMT-P | | Non-Voting | ALS Provider Oswego |
| Ware, Lucy | EMT-B | | Non-Voting | BLS Provider Cayuga |
| Wirtz, David | M.D., MPH | X | Voting | Emergency Dept. Physician Cortland Memorial |
| | | | | |
| | | | | |
| <i>Staff</i> | | | | |
| Eckstadt, Tamara | | X | Non-Voting | CNYEMS Program Administrative Assistant |
| Jones, Jeff | EMT-P | | Non-Voting | CNYEMS Clinical Consultant |
| Price, Colleen | EMT-P | X | Non-Voting | CNYEMS Clinical Consultant |
| Surprenant, Susie | NREMT-P | X | Non-Voting | CNYEMS Program Executive Director |
| | | | | |
| <i>Guests</i> | | | | |
| Ahmed-Scevwar, Nabila | | | | Crouse Pharmacist |
| Calley, Brian | | | | TLC EMS |
| Morrissey, John | | | | NYS DOH EMS |
| Hansen, Trish | | | | TLC EMS |
| Fricano, Lon | | | | TLC EMS |
| Seth, Naveen | MD | | | SUNY Upstate |
| | | | | |

Olsson: Ready? Okay. So we'll call to order the Central New York REMAC meeting for Thursday, April 8th. ___ be sure that you please identify yourself and speak into the microphone. Be wary of all the idle chit chat because it can be picked up. We are going to have to go into executive session so I would like to see if we could wrap up the "public" session of the REMAC by 6 or 6:15. The executive session could be somewhat lengthy because we have a lot of topics to discuss so during the public session I always welcome everyone's comments, but I would request that you keep them targeted to the point, please be short. The meeting minutes for January 14th were sent out electronically. Any corrections, additions, deletions and/or motions for approval we'll entertain that now.

Unk: I'll make a motion to accept.

Olsson: We have a motion to accept. Do we have a second? Dr. Burns. All in favor?

(Ayes)

Olsson: Opposed? _____. SEMAC/SEMSCo. SEMAC met in a marathon session on February 23rd. Medical Standards was in the morning. REMAC – SEMAC in the afternoon and SEMSCo in the evening and it was not comfortable. What happened at State Council. New York City has a hypothermia protocol which was passed and there's a similar protocol being done in Buffalo and Albany with fairly decent results. New York City also passed a modified triage protocol that incorporated an orange level. These are for patients that are worse than yellow, but not quite red. The gist of it is that if they include the non-traumatically injured medical patient who by virtue of being in a traumatic event is now seriously ill such as the COPD-er that inhales smoke secondary from a fire or from a building collapse who is on the verge of being almost intubated. They're trying that out and seeing how that works.

The Safety Tag is finished or is close to finalizing the recommended procedures that should be done, that should not be done in the back of a moving ambulance and that will be sent out from the DOH as an advisory. From DOH Office, the budget is what it is. There was a mention of moving EMS to Homeland Security so we'll see how that would merge. Emergency Management, Health Department, Fire Prevention and Homeland Security into one agency. St. Vincent's Hospital in New York is on the verge of bankruptcy. EMS Memorial, May 19th, at 11:00 a.m., there will be three names added to the tree so if anybody is available to go to that. Vital Signs is in New York City in 2010. It's August 28th weekend. Registration is now all on line. Some of you may remember that the Governor signed a bill allowing EMS providers to give vaccinations and it was 30 day or 90 day bill. That expired in February and as of this meeting in February, there was still something in process to allow that to extend, and we haven't heard one way or the other. Ketamine was added to the formulary in a previous meeting and the Bureau of Controlled Substances is working on the process by which you can use regulated, etc. There seems to be a sentiment amongst downstate providers that all VA hospitals supply the same level of care, meaning stroke, trauma, cardiac bypass, APCAs, I informed them no _____. Revatio which is sildenafil being used for pulmonary hypertension fits in the same category as Viagra and those classification of drugs so be aware of it. There is a bill in the Legislature. A skilled nursing facility that has more than 50 clients will be required to have an ALS ambulance on site and staffed 24 hours a day 7 days a week. I'm not sure where that's going, but it's in the Legislature.

(_____)

Morrissey: Skilled nursing.

Olsson: Skilled nursing home _____.

On site.

Fully staffed.

Olsson: Fully staffed.

(_____)

Olsson: Skilled nursing. There are two recommendations in Part 800, Article 31 would be requiring a defibrillator on all transporting BLS ambulances and _____ available throughout the State on all transporting BLS ambulances. Blood Council approves the concept for the use of blood products in transporting EMS agencies. It's gone back to legal, then onto the reformed committee, then to public review, then back to the Blood Council and then somewhere for final approval. REMO and a couple of other regions are doing an intranasal Narcan study, that's going to start this summer.

Basic EMTs?

Olsson: What?

With basic EMTs?

Olsson: With basic EMTs. That was the gist of that day. Moving on. Air Medical, Warren.

Darby: Air Medical met today at noon. We had the following agencies, air medical agencies present: Mercy Flight Central, New York State Police, Life Net and Air One. We spoke – we did a review of the statistics from the clearinghouse in the first three months of the year and we have extra print-outs of those charts. Should any REMAC member want them, see Tammy. We also went over a couple of audits, a couple of audits on requests for air medical services in Jefferson County, one was a baby that was a burn, second degree burn and there was weather that didn't allow the agency to fly in to that location, but the call didn't get back to the clearinghouse to see if there was any other agency that could fly in from another direction and that was dealt with. We had a Jefferson County ATV child accident, age 10, unconscious, unresponsive, that particular different air medical service was coming in from the north and had an ETA of 35 minutes

initially, then it turned out they had the wrong coordinates and they had 35 and 25 minutes ETAs to the point of which the ground crew came in ____ to the trauma center by ground and they cancelled the air ship _____. We have the lawsuit that we've been talking about for 2-1/2 years resolved by the Northern District Federal Courts here in Syracuse as of 6 of February, Judge Fred Scullen, Sr., a United States District Court Judge, "The Defendants' motion to dismiss be granted in its entirety." The Defendants were the New York State Police, Onondaga County Sheriff's Office, Central New York REMSCo, and TLC EMS which is the clearinghouse." They granted our motion to dismiss. It orders that the Plaintiffs' cross motion to amend the complaint is denied and is futile and the Plaintiffs were Mercy Flight Central and Air EMS Services of New York. It orders the Clerk of the Court to enter a judgment in favor of the Defendants and close this case on the 6th of February. Within a week, Mr. Hyland and I were discussing the importance of getting the clearinghouse notice to them when they're in service so that we do not have an EMS air medical service closer to a patient that we don't know about. The issue just before this call that occurred we had an entrapment crash up in the northern part of Onondaga County, Soule Road, and the closest available on the grid was Life Net Guthrie out of Pennsylvania. As it turned out, the entrapment was such that Guthrie arrived as they finally got the patient extricated and packaged so there was no delay. There was discussion at the table by all present about how long or how far away, it doesn't make sense to come up from Pennsylvania with an air medical service and then fly a couple of minutes to Upstate Trauma as opposed to in Onondaga County by interstate we can get there once the patient is packaged and on the road and fairly quickly and keep that air medical service available for the southern part of our region. Mr. Hyland agreed to call in and to also identify which of the two air medical services were being called in, whether it was Canandaigua or whether it was Marcellus and they have been doing that so we now have all of the air medical services in the grid, and we are following the direction of our Medical Director and that is the closest available to the call will be getting the call whether it is a public

safety ship, i.e., State Police or Air One, or whether it is a commercial ship and that's been working well in the month that we've been doing that. We had some discussion on Upstate's helipad. It is the new one, it's not open yet. There are some issues. Apparently the consultants were told that we have prevailing easterly winds here in Onondaga County which is 180 from the truth and so there are some issues with regards to the approach as we were up there doing some practice this last month and there are also some, I think, it is some HEVC towers that cause, from certain approaches, the decline angle of an increased – greater than what the FAA approves so it's not open yet and we have the regional helipad. We're still asking Upstate to consider keeping both pads in service which will give us depending on what the weather is the ability to use either and we haven't gotten an answer to that yet, but we're asking. Mr. Morrissey brought to the table the new policy on the temperature of drugs maintaining a temperature. We discussed the specific drugs. The temperature tolerance of meds is an issue with the ground rig, but it is also an issue with the air medical air ships so there was some discussion on that. We will be meeting again on the 14th of October so we've got the summer ahead of us and that was it. It was well attended. A lot of good discourse amongst the services that were there. Any questions? I want to thank TLC for continuing the clearinghouse services to the region. They sweated through this same lawsuit for 2-1/2 years as the rest of us did, but the right decision was made by two courts, the Western District and then Northern District. So I think that particular case is over.

Olsson: Okay. Thanks, Warren. CQI, Program Agency, Susie.

Surprenant: Susie Surprenant with the CQI, Program Agency report. Cortland, we do not have any current or closed _____ since January, since the last meeting. For Cayuga County, we have one med error that we are investigating and one esophageal intubation case that was closed. For Onondaga County, we have one intubation case that's currently open, one med error review as well

as a trauma call that we're investigating. So there are three open cases in Onondaga County. In Tompkins County, there was a med error case, that is now closed, we're just waiting for _____. In Oswego, we will be going into the executive session for further discussion about that. For the Program Agency, we – after the January meeting, the protocols did go out for the mandatory comment and review section and ____ for today's vote. And lastly we did a successful inspection of _____ Ambulance for ALS and paramedic level. That inspection was done and they did pass after adding some additional equipment that was missing and taking care of some expired medications and other equipment, but once they replaced that they passed the equipment list. _____ wanting to upgrade their ____ and by-laws and they have passed inspection as well. EMS Symposium, which is the EMS teaching day, is being co-sponsored this year by St. Joseph's Hospital and Upstate as well as the sponsorship by Rural Metro and the Central New York REMSCo. Hopefully that will be well attended again. It has been well received in the past two years. Of all the EMS teaching days the hospitals have put on so providers are appreciating the education. There were a couple of our course sponsors that teach EMT courses in our region have expressed for more CLIs so we put on the prescreen, we have 20 candidates, 19 that I have processed so we will be putting those people through a prescreen this weekend so that's going to assist our program and our course sponsorships so they can run the courses that we need to continue providing education for our new providers and recertifying providers. We also – we're looking to do a CV evaluator original course in Onondaga County the first of the year and then the following for Cortland, Tompkins and Oswego so we'll be asking some of the physicians to get those accomplished with Colleen, Jeff and myself. The other thing that we discussed for CMEs was adding a controlled substance station to our yearly CME ____ results of that. We will have one station in June and then one in December. We will get feedback from them _____.

Olsson: Any questions for Susie?

(_____)

Surprenant: _____ On the web site, there is the annual regional EMS awards, ____ physician, there's RN, educator, leadership award, agency award, so if there's anybody that would like to be nominated, the forms for admission are there. The deadline is the May REMAC or REMSCo meeting _____ at the awards banquet in July and the winners of the regional awards get put in for State awards. I'm very happy to say the last two years we've had two regional awards that went on for State awards.

Olsson: Okay. Requirement by the State to read violations. Thomas Sykora, surrendered his EMT in violation of Part 800, Robert Cornell surrendered _____, surrendered certification, multiple violations of Part 800, Louis Zacchio, suspended for 30 days, regional ALS, Part 800 violations, Merle Shelley, Part 800 violations, probation for three years, civil penalty of \$2,000, Dawn Giacobbe, Part 800.16(b), three year probation and a \$1,000 civil penalty. Old business.

Surprenant: One of the things that we agreed to do _____ is notify this body, all the agencies that have gone from BLS blood glucometry. So currently we have 13 agencies. We have SIMVAC, Cornell, EAVES, Mattydale Fire Department, Minoa Ambulance, NAVAC, NOVA, Menter, Pompey Hill, Throop Fire Department, Trumansburg Fire Department, Weedsport and WAVES currently doing BLS blood glucometry. In one of our ____ pods that we did for regional _____ there were some BLS providers doing blood glucometry _____, but that agency is currently not on the list. I was told by that agency they were not _____, investigated that and reported back to Dr. Olsson. We also _____ added fentanyl to the protocols that we would give you an update quarterly of the agencies currently approved by the State to administer fentanyl. We have four in Onondaga County, SAVES, WAVES, Rural Metro and Manlius Fire Department and one in Tompkins County is Bangs.

Morrissey: John Morrissey, New York State Department of Health. There's been a little confusion about what the approval process is for fentanyl. We have had a couple of services that just turned it in _____. You need a very specific letter signed by Gary Tuthill. It's a specific endorsement, your references, your _____ license for _____ so agency medical directors _____ specific letter to allow you put the endorsement on their _____ certificate.

Surprenant: Under old business, I'll give you the EPCR update. September of '09 is when this region first went live with agencies using EPCR. As of today, we have 15 agencies using electronic PCRs, 14 with EMS Charts, 1 with Zoll. We have 4 agencies in the training mode with EMS Charts and as of today we are 60% electronic _____. By the time the other agencies are trained we'll probably be close to 65, 70%, in a short period of time. So I think that all the agencies that are electronic and are moving towards that goal.

Olsson: As far as the RSI, that's an ongoing discussion, and an ongoing project. As you may recall from the last meeting was a list of providers, and we will be discussing those providers _____ in the executive session, plus the fact that it will be individual personal discussions and probably on something that _____ passed. _____. We will certainly keep this group up to date as to where we're going and what we're going to do. I can tell you my own personal view point is that we have to get this right the first time. We don't have a second shot at it so we're doing everything we can to make sure that we've got the right people in the right place and the right everything _____. More on that. Now, there were a couple of things that we talked about in the CQI manual and a couple of protocols.

Surprenant: Where do you want to start? _____ The three protocols that are coming up will be acute respiratory distress, pulmonary edema and interfacility. What you see is what we voted on back in January, it went out for comment and review. We received one comment asking if we're mandating a specific manufacturer for capnography. We are not.

The devices that have been approved for EMS use, we'll leave it generic just like we did for the adult FIO. Down at the bottom of that protocol was also, we wanted to add contact on-line medical control if CPAP was utilized. For pulmonary edema, the same considerations for CPAP, also contacting on-line medical control and the decision in January was to remove the second dose of Lasix which was 80 mg. Otherwise the remainder of the protocol stays the same. Interfacility, wanted to add the interfacility form that was developed and approved by this group so that is used for all interfacility transfers done in this region. Discussion was also to appropriately have the nitro drips that were originally at the paramedic level back about eight years ago and proceeded to move it down to the critical care level. The reason you see CC protocol drips and protocol drugs basically outlined and those will be deleted is they are already existing in the protocol so that was repetitious. We already have protocols for all of the medications that we carry for the critical care and paramedic levels and they follow the appropriate protocol. So if we're transferring someone, for example, that develops chest pain, then the provider will follow the chest pain protocol or respiratory distress. So we felt that was redundant and adds just confusion because I have had multiple calls from providers asking what that meant in the past. So basically this finalizes it and we will get it approved from SEMAC so we can have nitro drips down at the critical care level. Questions?

Olsson: Okay.

Surprenant: Any comments on those three? This is pretty much what we voted on back in January. We are obligated with the protocol approval process for SEMAC to come to a final vote here. I've already talked with the State and we will be on the agenda for the end of May SEMAC meeting for final approval.

Olsson: Can we get a motion, a second and a vote to approve it to take this to the SEMAC?

Motion.

Second.

Olsson: Any discussion?

Iannolo: This is Dr. Iannolo. I apologize for not having been here for the previous discussion. My question about CPAP, do we train the providers in the process when to decide if CPAP is failing or are we going to give them some indication of how long they try CPAP for, what parameters for pulse ox and ventilation to follow, then when to decide it's not working so they move on to intubating the patient.

Olsson: That would have to be in the training piece as opposed to being in the protocols. I don't know as we put treatment failures in other protocols. We just do it step wise so my understanding would be that it would be similar here, that they would go ahead and utilize it and in the training we would have to put in an educational piece that if it's not working, then move on so that's the training piece. Any other questions, comments? All in favor of these three protocols as written raise your hands. Opposed? Abstained? Carried. Do you have that one page that we talked about, page 6 or whatever that is?

(_____)

Okay.

Surprenant: For the sake of _____, this is the same manual that we sent out electronically to the REMAC physicians. Also, we sent the draft to the CQI contacts for ALS agencies and we also got four copies that were just sent out, but what we did was go in and highlight. One of the things for the State, the State updated their State CQI manual, and we went through ours to make sure that nothing conflicted and that we referenced that correctly, similar to what we have done with policy statements to make sure that ours are coinciding with theirs and do not conflict. One of the things that we have in place is a process that Dr. Jastremski and that REMAC at the time put into place for the agency level CQI, county level CQI, executive, regional and this body for REMAC. So that structure

has stayed the same over the years. The document has just changed to reflect any changes with the State's. The nice thing with the State CQI manual is that they put a lot of _____ in their appendices, they have some tools for auditing cardiac arrests, for diabetes, for respiratory, also if an agency wants to do some agency review, so there's a lot of nice tools that they have for an agency that doesn't have existing forms because we have got some smaller agencies that just don't have the resources so instead of redoing that we've got references to the State manual so we don't coincide. Brian Calley had a couple of good suggestions after reviewing that and you will see the things that are highlighted, we just wanted to show you – if you could go to the top of that page -- _____ for the comment to add part 80 in there which deals with controlled substance so we've got that added. We made no reference to our policy statements which policy statements are _____ we have those at the regional level and State level so this way we have a reference somewhere in the documentation that shows the people what our policy statements are said to exist and also what the standards are in the regional CQI manual. So there are many standards from the State policies to our protocols, the State protocols and then we've got all the Public Health Laws, Article XXVIII, XXX, XXXVIII, Part 80 and 800 reference. So we kept those in there as well. Basically in this section we also just show that it is a partnership between agencies and providers to provide medical oversight and that we're at – basically initiative for QI is the quality of patient care, that it's not a punitive process, that it is suppose to provide quality of excellence and good patient care and positive feedback for providers, and then also referencing the role that REMAC plays in the CQI process. The rest of the levels, the reportable incidents, basically we just – it stayed the same as was reported to the region and then of course the Part 800 which we are required to report and 800.15 which references required conduct by providers. 800.16 suspension and revocation when patient is harmed or potential for harm or patient death, all those we are required to report to the State. So that has stayed the same. There was a 24 hour window for those prior – Brian

had a good suggestion, 24 hours was very vague and where we have now in there is that it is basically when the agency is notified. Say that we have a call that happened two days ago, but the agency only finds out about it today, they can't report it 24 hours ago if they didn't know about it. So this is 24 hours from when they were notified of it and that refers to the 800 as well. The nice thing is all the systems we have in place for reporting, whether someone uses the web site or email or fax, even the voice mail now, everything is time and date stamped so we do have an electronic – someone said so what happens if it is on Saturday, it really is time stamped so we know exactly when something comes into the office. One of the things that we have was more detail from the agency level. There are a lot of smaller agencies, especially in our rural counties that only have a couple of people that sit on CQI that said can you give us a little bit more guidance than just referencing Article XXX, Section 3004, this is CQI, this is what you're required to do. So we took some of the verbage out of the State's manual and put in here so those both coincide. We also put in there where the BLS/first response agencies in your PAD programs, the BLS/first response are not required under the Public Health Law to do CQI, but we're encouraging them to attend as well. With the PAD and epi pen, those incidents of use are required to be reported to the region, and we in turn report that to the State so we just wanted to remind those agencies because we still have agencies and actually companies that have AEDs out there that realize – they don't know that they have to report and we are just constantly reminding people, here's the form, and yes, you do have to report. We have over 400 PAD sites and over 80 epi pen sites, and we are getting more reports of use which is good for the system. Slow down one sec here. ____ for the agency level was also _____ section that we had before of the standards and just remind for the agency level that those standards do exist, but that was exactly what was on the previous page and this just goes through the committee and suggestion – CQI coordinator. So this references the State's policy manual and also the tools that are in that manual that _____. The thing that we added, the guidelines for an agency stayed the same, but also besides reading the confidentiality statement

and having a record of attendance, we just assumed that before, but it was never anywhere in writing to keep that. This is referencing regional nominations when this manual was there. There was not a system in place for regional nominations. It also references the May REMSCo awards that occur at the awards banquet and also the recipients get forwarded to New York State. We have a process in place for them, in writing in a manual, and to have a system in place for agency level of any near miss report, if you're an agency medical director. Basically that section in yellow referenced that if a provider disagrees with their agency medical or CQI, that they have a way to appeal the decision. The verbage for regional, county and executive basically stayed the same. It's just reminding people that when you have your meetings, also forward us the minutes. We do have counties that do that on a regular basis already, that's just a reminder as well. Meeting frequency is quarterly, just like the REMAC. An accounting issue, this one came up because they were having trouble getting _____. They had people representing multiple agencies which did not always give them _____. Also referencing a record of those in attendance. The Regional QI Committee, even though we keep a record of attendance, there was something in the manual of the State Council and we made sure that was consistent for agency all the way up to the REMAC. The same with executive, it did list previously the reading of the confidentiality statement, record of attendance, we wanted to make sure that was consistent _____. And then the record keeping, what's required, we referenced _____. What we did was even though in previous documents, this was mandatory requirement, like patient abandonment, patients harmed, all it is, it is a line, and there were a lot of agencies calling and asking for a description of what that meant and so some more detail from what we were referencing so in each of these you will see _____, so basically on the previous page we described what this patient abandonment reference, but then all we did was we asked step by step so an agency could look at this if they haven't had a case like this in a while, it was reported with documentation sent to the region in the time frame, the documentation that the

region will be doing, the reference to Dr. Olsson and his review of the CQI issue and the plan and it's just a step by step of what currently occurs, but was never in writing so people could look at that and go okay, I've got to do X-Y-Z and have just a quick tool without having to look through 12 pages of manual of what's reportable. Basically these next few of them, the only ones that reference report to the State are the 800, like patient harm, patient abandonment, those you will see a reference that we have to report to New York State representative. So if an agency that has one of these doesn't look through the manual just looks at the appendices, they'll have a quick reference, a chart basically, an algorithm similar to our protocols so that they can follow step by step.

Colleen: The remediation plans all initially came out of county CQI, each one was assigned.

Surprenant: Prior to Tim leaving and REMAC back then it was asked of county CQI for suggestions on remediations. There was another good suggestion and we've talked about this to having some tools in the back and more in the appendices of having the actual forms for remediation so if someone has a medication error, that this is the education that you give that individual so there's consistency between agencies. Not all agencies have CICs to rely on and not all agencies have CLIs to rely on. A lot of them have not even CME evaluators. There are people on the CQI committee that meet, you know, quarterly and get together and read PCRs, but they don't have the instructor's piece of that so it has tools for them and that is something ____ show this group for the remediation piece and add to appendices ____.

Colleen: They're having trouble coming up with resources, they contact the office _____.

Surprenant: Any questions on that? We all have the electronic version of this as well as the CQI contacts for ALS agencies.

Olsson: So what we would like to do is to move forward with the approval process unless somebody has some...Lon Fricano from TLC.

Fricano: Is there any guidance in the new manual that helps focus the discussions of the CQI committees: a lot of times we get a collection of EMS people in the room and the discussion may wander off the subject so that they're not pertinent to CQI. So maybe somebody says _____, oh, yea, me, too. That's not obviously a CQI kind of discussion, but if it occurs in a CQI meeting, you know –

Olsson: That would be up to the leader of the meeting.

Fricano: My point is I think that we've experienced some just recently, had some discussion _____ what should we really be talking about, I'm just wondering since you are, you know, putting this new manual out or updated manual out, I think a lot of the people who are participating at the county level could use some specific guidance on that subject.

Colleen Price: (_____) unintelligible – no mic

The manual that we're putting out for the county – for the region is a supplement to the State one. There is a form in the back of it that you could use to discuss a call that would help keep things on track. The _____ manual we didn't want to reinvent the wheel. There are a ton of great resources to focus and direct CQI _____ so to say we're going to use this form for this meeting, and this form that meeting _____.

Surprenant: Also, Lon, there was in the previous, there was a section that refers to the county CQI what the meeting content is and it says develop _____. I know in Oswego County when I go there, we actually go around and discuss what each agency is doing in their CQI process. So we had actually had a very good brainstorming session _____ best practices, how people are reviewing calls, what kind of calls they were reviewing and actually bringing some to the table and say, okay, we're going to review this cardiac arrest, then your agency brings that call to it. But we were actually just going

through since we do have some _____ agencies up there, sharing best practices so it was very beneficial.

Olsson: Okay, so any other questions, comments or motion to accept and approve the CQI manual as written. Some one needs to make a motion. Dr. Iannolo makes a motion to approve the CQI manual as presented. Now, we can make it a first, a second and then comment.

Unk: I'll second it. As presented with the aforementioned chart showing which things are direct State reportable and which things are direct county reportable _____ alluded to it. Actually that would be a fabulous thing to have would be a regional CQI manual.

(_____)

Olsson: Okay, very good. So the amendment is withdrawn.

Correct.

Olsson: So the original motion, it's getting more _____ now. All in favor of the CQI manual as presented? All opposed? Abstained? Carried. Okay. Any other old business?

Not at this point.

Olsson: All right, new business. We have two service medical director applications, not that one. First is from Lafayette, Dr. Nanavati, who is apparently a family practice physician, does not have a CV or resume and previous EMS experience, "through the residency". So as far as I'm concerned the application is incomplete and certainly a lot more information is going to be needed before it can be acted on so I'm going to take executive privilege and say we're going to table it for at least the next meeting and Dr. Nanavati is certainly going to have to provide a lot more information from our standpoint. The second is some guy named Dr. Markham who is applying for the NOVA Medical Director.

Surprenant: And GBAC.

Olsson: It didn't say that. That is separate. And GBAC? Okay.

Darby: Have we done a background check on that man?

Markham: Please don't.

Olsson: He does have an orange jumpsuit _____. All right, in any event, I will accept the application as submitted and open for discussion, nomination or motion to accept.

Motion to accept.

Second.

Olsson: Any discussion? All in favor?

(Ayes)

Olsson: Opposed?

(_____)

Congratulations.

Congratulations.

Olsson: All right, okay, do you want to do the _____

Surprenant: We have two ALS upgrades in front of us. We've got TLC, actually let me correct that for the record, it's TLC Medical Transportation Services, Inc. has been granted an ambulance certificate from the New York State Department of Health for Onondaga County. The agency code is 0938. They are currently operating at the BLS ambulance level, and they will be staff leasing personnel from TLC Emergency Medical Services, Inc. which has more than 100 providers to staff their ambulance serviced 24 hours a day, 7 days a week, all of their providers currently work on the

ambulance and are current with Central New York CME requirements and also are credentialed by the Central New York Region. TLC Emergency Medical Services, Inc. has 40 EMTs, 2 intermediates, 13 critical cares and 44 paramedics. The staff providers work the following operations: TLC Emergency Medical Services, Inc. in Cortland and contract operations for Auburn City Ambulance and Brewerton Fire Department Ambulance. Their medical director is, who has been on our REMAC for quite some time, Dr. Patsy Iannolo, who also serves as medical director for TLC Emergency Medical Services, Inc, Auburn City Ambulance, Brewerton Volunteer Fire Department Ambulance and also NAVAC Ambulance. We're requesting an upgrade to an advanced life support ambulance service for TLC Medical Transportation Services, Inc., described to provide the best services to the patient and upgrade to ALS will allow our patients with the highest level of care available. And the other thing that we've done with these before in the past is scheduled the inspection, so the inspection is scheduled for this upcoming Monday.

The upgrades for this body are to make sure that any agency meets the medical standards pursuant to that level of practice and we will evaluate their equipment, the minimum standards. They meet the minimum requirement as far as certification and agency medical director. So we would entertain a motion that pending a successful, complete, appropriate site survey evaluation that TLC be granted ALS privileges within Central New York, specifically Onondaga County. So

—

So moved.

Do we have a second? Discussion?

Morrissey: _____ the agency code number, all you have to do it ask for this later.

Olsson: Relative to the agency code 0938 to be specific.

Morrissey: It gets muddy otherwise.

Olsson: Any discussion? In any case we will call for a vote. All in favor? Hands? Abstained? Two. And opposed? _____. EAVES.

Surprenant: EAVES Ambulance has a current ____ that is at the BLS level, they are requesting an ALS upgrade for that. Their medical director is Dr. Cooney and their inspection is scheduled for Tuesday.

Olsson: So a similar situation, they've met the minimum basic standards, they have an inspection pending and we'll entertain a motion that if they successfully complete that inspection, if their EASV upgrade, ALS be granted. Second? Discussion? All in favor? Hands? Opposed? Abstaining? Passed. Okay.

Surprenant: One of the things that we report on quarterly to the State in our deliverables is how many PAD agencies that we have in the region. Epi-pen. Now, we are also reporting how many medical directors we have, agency medical directors. The other thing they want us to know how many agencies that have been approved by REMAC for albuterol. The process has not been in place in this region to do that and I've talked with other program agencies we're not the only ones. The nice thing the medical director verification form has a section for albuterol on that. The thought is if you waited quarterly, we could get the current application for a medical director, a patient form that now has albuterol _____ before this body met. My thought was that we do it similar to glucometry, have a system in place, they meet the minimum ____ then come back to this body with a list of who has been approved for albuterol which quarter. Basically what we would need to show is that they have a current medical director verification form signed on file and I would recommend that they have an agency letter stating that they have trained their providers and they're following BLS protocols. We already have a policy statement in place saying that we follow BLS protocols for this region. So that

as long as they do that training then they will be in compliance. That's my suggestion.

Olsson: So do you want to put that in a motion?

Surprenant: For the REMAC to approve agencies to use albuterol in the Central New York Region to streamline the process, agencies would submit an updated medical director verification form as well as a letter from the agency stating that they have trained their providers and they're following the New York State BLS Protocols. In turn, I will give a quarterly report at our REMAC meetings of these agencies and will be reporting the deliverables to the State.

What that translates to is _____, rather than us voting on each agency for each albuterol or each epi-pen, if they meet the standards we approve it and then we have reports on it.

Price: Just a question. We have a lot of agencies, BLS _____ would that include those agencies that are already reporting on a regular basis to the web site as CME managers?

Surprenant: The albuterol is different, it's not the agency providers putting in, they want to know how many agencies in our region and approve at our REMAC meetings the albuterol.

Price: So even though they're reporting, go ahead and do verification form, get a letter from the medical director and send it in.

Surprenant: That's for upcoming, the ones that are in the future, what we are doing currently, the other thing that we're reporting is the most up-to-date information for agencies. So what we've done with the protocol update is sending the agency a screen shot of what we have for contact information for the agency which includes address, phone numbers, who their primary contact is, who their medical director is, who their CME manager is, who their QI manager is and we've sent that out to the ALS agencies currently to verify. Anybody that we do not have a current medical director verification form on, we're getting a current

one to file and we'll file it with the State so that they have it on file as well. Looking in the past, we don't have – all the agency files do not have medical director verification forms so they may have been sent off to the State _____ so what we are doing is making sure we are all compliant, the ALS agencies will be reported to the State. Once we are done with the 63 ALS agencies we will then start with the BLS agencies and do the same thing. The nice thing is we're also finding out some more medical directors, we found out in Fabius they are claiming the same medical director as Lafayette is, so I believe this will help clean up some of these issues where people have not gotten their agency medical directors approved. For the most part in looking at the list, it's very comforting, but I want to be able to show this body a spreadsheet which will be already compiled saying that these are who the medical directors are for these agencies _____.

Price: When I go back to the EMS Council, what do I need to tell him he needs to submit?

Surprenant: BLS, right now. _____ you will hear from us.

Price: Excellent, that's what I wanted to hear.

Olsson: Any other new business?

Morrissey: We've been getting a lot of phone calls on _____ about _____ and requirements related to temperatures and policy statement out on that. Please realize that policy statement was done because of moving toward carrying blood productions _____ we need to look at this stuff, QA it, your garage temperatures, epinephrine is one of those nontolerable _____ and so keeping an eye on that makes a lot of sense. One of the last things, I would like to just announce in case anybody doesn't know, Jim Jones, some of you may know Jim as a long time quality assurance person here. He has accepted the position as the full time County EMS Coordinator for Oswego County and he will be in a much better position to support the REMAC _____.

Butler: Dave Butler, TLC. I know tonight _____ but we need to _____.

Olsson: The only thing that I can tell you is that the hospitals are keeping track of it and it's a hospital issue that impacts EMS. Before I put my foot in my mouth, I'm going to stop.

Me, too.

(_____)

Unk: This is in regard to the _____, than anything else. In the current protocol it is classified as a ___ cotomy with a quick trach device. In developing the RSI program, we were looking at something that may be a little bit more reliable than _____, it was a device that was highly tested _____. I understand that this is more of an upgrade as opposed to a protocol change which _____ protocol change. It's called "the cricket" essentially it is just a very simple little device that is packaged a little bit differently, but it is technically not in _____ so we need to make that change.

Olsson: If it would be acceptable to this group, I would be willing to draw up the memo or a statement of some type that basically rewords that particular procedure, any type of prehospital emergent cricoid thyroid device may be utilized in place of a needle because it is just an equipment change. If that's agreeable to everyone, then we'll draft up that letter and send it out and then _____. Does anybody have a ___ problem with that?

Iannolo: This is Dr. Iannolo. Will this _____ device _____ says that this is the next best thing to use and the agency just decides that they want to use _____.

Olsson: Well, we've done this with other like spineboards.

Unk: This is a little more invasive than spineboards.

(_____)

Olsson: We talked about drafting a list of acceptable stuff and we've never done that because we just quite honestly haven't gotten had the time or the energy. If we want to as a group come up with a list of acceptable cricothyrotomy equipment or anything else that is interchangeable, I would have no problem with that. I don't know how far, how convoluted this group wants to make it. I'm open for suggestions. Do you want to make a list and we can say the following equipment meets our needs?

(_____)

Price: The IOs as far as the site, yes, FDA approved _____

Olsson: That is how we ended up with _____, wasn't it an FDA approved device.

Right.

Price: (_____)

Morrissey: Let me just – John Morrissey, State Health Department. Let me point out to you that a few of these devices have been around for a number of years. As an example, trans-jet ventilation device. That has been on the market for _____ FDA approval as an example. I think the _____, device makes sense. Surgical grade may be something else different, it may _____ different approach. However, you want to do it is up to the REMAC _____, that would be my personal interpretation.

Cooney: _____ I thin if you make it too vague _____ scalpel and endotracheal tube _____ so it depends. I'm not familiar with the device _____, but if it's something for a procedure technique _____ probably should specify _____. The other issue is _____ multiple agencies. I have to be sure _____ they know how to use the device that that agency has. _____ so if the provider works three agencies, you say you can

use any supraglottic airway device _____, that's fine, but that means they better be good _____ . They better be able to prove ----- . I'm not a big believer in restricting the specific commercial devices _____, but I think the _____ be a little more specific, to think that techniques are very different so I think maybe we should ____ list for _____ .

Surprenant: If we look at past practices we always put equipment in our policy statements, medications and procedures have always been in our protocols. We already have a minimal equipment list that for the ALS. There's nothing stopping us from revising that and adding acceptable equipment on the bottom. We did that with the adult IO _____, specific for certain devices, we can easily update that list _____ which pieces of equipment. I think the nice thing with that is that we saw with memos going out that the nitro drip, memos got kind of lost. The nice thing is when you have protocol book and policy statements, you have two things that people go to and that's one of the things that we carry for providers. We've got multiple resources. We want to know that as an ALS provider they have to go through a protocol book, a policy statement and they don't have to look anywhere else, so I think just think from a consistency standpoint.

Olsson: Why don't we do this and then _____ the question. Dr. Fullagar, if you could send me a list that outlines acceptable or potential products that are reasonable, then we can disseminate it and everyone can comment on it, then bring it back and then between now and whenever we can converse electronically and then we can figure out how we're going to do this.

Fullagar: I think that _____ for all of the reasons mentioned. Derek, this is _____ for our needs _____ as well. And so where this came from was actually a discussion in regard to the air medical airway management and that's kind of where this came from. And some of the issues that we've had in the past with the needle cricothyrotomy __ and so this is really different and then _____ seeing

the landmarks, seeing true confirmation, etc., etc. _____ .

Olsson: All right, so we will work on that over the next couple of months electronically.

Markham: I'll try to get through this quick. I just wanted to discuss the recent change with the EMT-I's in placing of IVs. As the new protocol book came out, apparently as it was planned or inadvertent I'm not sure, that the EMT-I's can no longer place an IV in a patient ____ ALS arrival without medical control, well, evidently that passed. I'm not sure why that was taken out of the protocol. It is something I think we ought to let our EMT-intermediates do. Do you have any thoughts on that?

As far as their training –

Olsson: ____ in the previous versions, the previous versions ____ . It centers around the fact that in trauma patients, ILS providers are allowed to start an IV, medical patients they are not unless they call medical control first.

Markham: And full arrest patients they're allowed to start an IV.

Right.

Markham: I guess my question is, why not allow them to do it for a medical patient?

Olsson: We're trying to get out of that.

Surprenant: Yes.

Olsson: Because it's in trauma, that's the problem. This is going to do it. It may just be – it could just be – the way this is set up, yes, see this is just in trauma.

Surprenant: Warren, do you have your laptop?

Darby: I do.

Surprenant: Can you see the wireless here to do into the LAN?

Darby: I think I can _____. All it is in the trauma _____.
(_____)

I don't think we need a computer to answer that question.

Olsson: What?

I don't think we need a computer to answer the question.

Olsson: Well, it's a reasonable question to ask _____ ILS providers to start _____.

Olsson: We actually changed it on this protocol. We took it and made it that way, which I had completely forgotten about. So the question, I'll have to support Dr. Markham on this, I have about 17 or 18 years of experience in responding with the ambulances in the rural counties, sometimes ILS people are on the scene waiting for the arrival of advanced life support, probably 85% of the calls in the rural areas are significant, life threatening advanced life support calls and these patients can deteriorate rapidly and it's not uncommon to arrive on the scene to find that you've got your hands full a long way from the hospital _____ initiation of advanced life support to save you some time and even get that IV line in before the patient goes into circulatory arrest. I think it's extremely prudent _____ I would have a hard time _____ intervention in anticipation of _____. I very strongly support what Dr. Markham is saying _____.

Price: (_____) I think the reason why it happened is because you had ILS providers that were putting albuterol _____ BLS respiratory distress protocols _____ then transporting them _____. So it was essentially becoming an ILS ambulance not an ALS

ambulance, and I think that's where it came from _____.

Olsson: So the question would be, change the protocol to the fact that ILS providers would be allowed to start an IV in medical patients as well as trauma patients and would not have to get medical control _____.
(_____)

That's the proposal, yes.

Olsson: Okay. Is there a second for that? Is there any discussion? So all in favor of the concept? Opposed? Abstained? So what we'll do is we'll draft a wordsmith to go out just so that everybody can see it and then could we sneak that into our State – and we'll sneak it into the State for the next meeting and so it should get approved at SEMAC.

Morrissey: I don't know that we need –

(_____)

You're not changing the scope of that _____.

Olsson: So we'll send out the wordsmith so everybody can see it and we'll make it happen on that.

(_____)

Olsson: We decided it was the right thing to do. All right, any other new business? All right, before we get distracted by something else.

Darby: The Deb Duethorn Scholarship Fund, REMSCo, her untimely death, is a \$500 each semester scholarship available for anybody that is _____ themselves in the field of one of four categories, EMS, fire, police or nursing. She was all of those. It's not a well known fund, it's on our CNYEMS.org website. The paperwork to apply for it is there. We're going to be making a decision at the May meeting so that we need the applications in by May

so we can award the fall semester scholarship _____, more mature folks, _____. It's on the website.

Olsson: In any case, I will entertain a motion to adjourn. Have a nice safe happy summer. We'll reconvene executive at quarter of.