

CENTRAL NEW YORK REGIONAL EMERGENCY MEDICAL ADVISORY COMMITTEE
Committee of the Central New York Regional Emergency Medical Services Council, Inc.

January 8, 2009 Meeting Minutes

Olsson: Dr. Olsson. We are starting the Central New York Regional Emergency Medical Advisory Committee meeting. Thursday, January 8th at 1713 hours. And we will begin by going around the room with introductions.

John Morrissey, New York State Department of Health, EMS Director.

Dr. Therese Witt, Chairman, Emergency Department at St. Joseph's Hospital.

Mike Kowalski, VA Medical Center.

Chris Fullagar, University Hospital.

David Wirtz, Cortland Hospital.

Joseph Markham, Community General Hospital, Assistant Director to ED.

Troy Hogue, Rural Metro.

David Nelson, Medical Director, Rural Metro.

Tammy Eckstadt, Administrative Assistant, CNY EMS.

Bob Loomis, Oswego County EMS.

Colleen Price, Central New York EMS.

Jerry Morrison _____

(_____)

(_____)

Sandy Hargrave, Lee Memorial Hospital.

Troy Hogue, TLC EMS

Warren Darby, Central New York EMS.

Susie Surprenant, CNY EMS.

Olsson: Okay, thank you. The minutes from the October meeting were sent out electronically. I don't whether everyone had a chance to read that. If there are any questions, comments, concerns, changes, please let us know. I will entertain a motion to accept the electronic minutes from the October meeting.

Motion to accept.

A second?

Second.

All in favor?

(Ayes)

Olsson: Opposed? Carried. The SEMAC & SEMSCO met December 2 and 3rd ____ standards. I sent out my notes in the mass email that everyone should have gotten. There is a couple of items that I will just mention very briefly. Apparently throughout the State there is a quandary to who provides on-line medical control. There are regions that have regional medical control rather than with an individual hospital. And it's not uncommon for paramedics staff ____ to be given medical orders from other paramedics. So the State is looking into seeing is that okay. Could there be nurses? Could it be physicians? Could it be PAs so again _____. But a letter was received from the Albany region regarding EMS taking care of patients in the ED. There is apparently one area in the State where a 3 hour turnover is not uncommon. The quandary is that unless you're part of a training program technically you can't treat a patient in the hospital. However, we do realize and understand that if this is an extension of care from EMS and realistically the hospital does not have the ability to take care of the patient so it is something that has to be worked out by the hospitals and EMS docs to understand that, and we're _____. Don't expect any more money in the budget. We'll leave that alone. The

blood transport issue is still in the process.
Mandatory equipment – The arterial tourniquets will most likely find its way into the mandatory equipment list about 2010. These are \$5 or so probably. The military is using them and they're very effective and very easy, more will come on that. So I will let ___ go back.

Witt: May I ask a quick question?

Olsson: Yes.

Witt: This is Dr. Witt, and I have a question. At times EMS will bring a patient in that they have been unable to intubate in the field. The minute that they are unable to intubate because they just have sedatives not, paralytic agents. As a physician in a teaching facility, it is my desire to give the patient the appropriate paralytic drugs and allowing the EMS to intubate in a controlled setting. Now, I've been told that I can't do that because EMS wants their license _____ and yet, isn't that really an extension of a teaching role. I mean I teach paramedics – I give long lectures, I do the preceptor courses, I really view that as sort of clinical teaching. Is it acceptable?

Olsson: According to this, no. EMS are certified licenses, there is one issue. It has to do with the fact that –

Unkn: You have to have a defined course number for this happen. _____ coverage under 825 so even an EMT _____, but if they are not in that environment, we don't have a mechanism to do it.

Witt: Is there any way we can look into it? I think that this is so valuable. When I'm working clinically, I have so much to offer them.

Unk: I know this is a hot topic State Council and they're working on it. It's been ongoing for a number of months. I think we need to wait and see what's done on that first.

Witt: Okay.

Unk: I think that's the best _____.

Olsson: The only potential light we have been able to come up with is possibly at the VA. Because the VA is Federal, they don't follow quote/unquote typical State guidelines.

Typically.

Olsson: And so they don't have to be part of a class, but _____ so it can be considered an extension of care, the reality is that' actually within the confines of hospital that is extending out from the ambulance. _____.

Wirtz: I'm Dr. Wirtz from Cortland. _____ myself.

Olsson: Now, something serious. Air Medical

Darby: Air Medical met today, and we had a great attendance. We had four services plus all 3 regions represented. We looked at the Clearinghouse Report which is an annual report in the last quarter and a summary of the year, along with the 3 months _____ it's a lot of paper. We have changed to a new company _____. It's the same company that is used by the TLC Communications Center. Staffing with our previous company _____. The companies point fingers at each other trying to say that it is the other company's fault regarding _____. Now it's the same company _____. We had the 59 PCR's utilized by our medical director _____, 3 Mercy Flight, State Police and Onondaga Sheriff's Office. There were no outstanding medical issues on those. We also looked at the one audit operationally on a long response time to Cayuga County daytime, the second of December, a 30-year-old male who fell off a roof, a 15-foot fall, and there was 46 minute response time, it was audited, looked at, what happened was they called for a stand-by, the 911 Center in Cayuga, and they said they were in-service _____, 10 minutes later they said they launched, weather can change, and now _____. They told the 911 Center

_____ response time . _____. That resolved _____. There was a discussion with regards to the frequency of multiple shifts. We have the policy right now through the committees that if we have multiple shifts in the area _____. There is apparently a national frequency 1123.025 which is the national _____. _____ license to change _____, and we are going to be looking into that. The EMS representative from the State told us in NTSB hearings on air medical hearing, 3 day hearing starting 02/02, it will be pod cast, go on to the NTSB.gov web site to see that. That should be an interesting event. We also had some discussions around the Mercy Flight lawsuit, and this is _____, we're just waiting _____ court calendar and hopefully the rest of the parties _____.

Olsson: Thanks, Warren. Any question of Warren?

Price: Colleen Price, Central New York EMS. For this month's review, we had 5 cases, several of which _____. The first case was an incident where a patient with a history of _____, was a BLS stand in, that was resolved with the agency's medical director and that case has subsequently been closed. _____. The second case was a case in which a patient with respiratory distress was inadvertently given incorrect medication. That again was resolved _____ and that case has subsequently been closed as well. The third case was a patient who, this was prior to the NIMS line protocol, just for reference, the patient had a episode _____. That case is pending and will be closed once that process is complete. The fourth case was _____ patient with CVA, who subsequently received aspirin pre-hospitally, that provider was counseled _____. The fifth case which was actually not a patient care issue so much as an unusual case of a 12-year-old who with no type of trauma or history was found to have a cerebral hemorrhage. _____. That's it.

Olsson: Thanks, Colleen. Any questions or comments? Program Agency office report. Susie?

Surprenant: Susie Surprenant for the Program Agency. This week we've had a flood of _____ that we are addressing, we'll bring that up in Old Business as well. We also have had CME questions _____. Currently as of 01/01, we have 4 agencies _____ PCR, we've got Bangs Ambulance, TLC, and also we've got _____ fire department and Dryden. _____ Tompkins County, Cayuga County, Onondaga and then Cortland, so we've got 4 of our 5 counties that actually have EPCR _____ so the nice thing we're trying the system out. We've got 4 agencies _____. _____. We're working with St. Joe's, got the computers in place. Cortland Hospital is also working with their IT department provide the same services. The advantage to the hospital is that they have got the completed chart quicker so the agency can go back to the quarters. Currently an _____ which is very similar to EPCR _____.

Calley: Yes, Brian Calley TLC EMS. So far since January 1st, EMS PCR program things have gone very well, they are staff providers _____ working with them. _____ from the time the crew closes the last chart is less than two minutes before the pcr is on the fax machines. _____. If anybody has any questions about this system so far, please feel free to catch up with me. I also some sanitized run reports to look at as well. Thank you.

Surprenant: CME classes are posted on our web site as well as any EMT _____. Last month we had 3 surveys, 1 for St. Joseph's, 1 for University and also _____. So we were able to do that from our web site. _____. Any questions?

Olsson: We are, as I am aware, by State law to read into the minutes, any suspensions and violations New York State, this is dated October 9th, this is _____, 3 violations _____, Mcaias Volunteer Fire Department, Jeffrey Tooksbury, remote certification for _____. Clint _____, probation 2 years. _____, suspended 1 year, probation 2 years _____.

_____, suspended 2 years, probation 3 years, _____ dollars. _____, certification _____. Peter _____, suspended for 1 year, 2 year probation _____. _____ violation. Mary _____ suspended 1 year, placed on a year's probation. _____, 1 year suspension, 3 year probation _____. _____ certification for _____. _____ All right. _____. We will go off the record and go into executive session hopefully no more than 15 minutes _____.

Olsson: We will move onto old business. The State as you know approved the spinal immobilization protocol and training was to be completed December 31st of '08 and the decision was made that we would not as a region anticipate this until we knew that every agency had been trained. Simplify the emergency departments, they didn't have to figure out who was immobilizing and who wasn't – so do we know -- _____, notify the emergency departments and the agencies officially when we are going to do that. We could have started it in September, but agencies – we had some agencies who didn't do their training till December 31st, and I know that for a fact. We are going to sending out to the directors and nursing coordinators as well as the physicians, the latest updates on training materials and protocols themselves, and we hopefully will be able to include when this region will start to perform that. Capnography, the advisory went out finally. Without going into a lengthy detail. It was a long drawn out procedure. _____ a more stringent version of that and basically as of January 1 continuous wave form ___ capnography is required on all intubations. Anything else on that?

Unk: _____, _____ cardiac arrest in Brewerton, and they were _____.

Olsson: Any old business? New business? New Haven Volunteer Fire Department

Surprenant: New Haven is currently an ILS service. The last 10 years they have been ILS and what spurred them to thinking about upgrading to ALS

was the amount of advanced providers they have, the fact that A. Lee Memorial will be closing _____ longer transport time _____, and also _____ capnography. So _____ if REMAC approves, they currently have 2 paramedics level, 6 level 2 and 6 basics they have another student in a level 3 class, and _____. Their Medical Director is Dr. _____, works part time in the Oswego ER _____ and what they would like to go to ALS and paramedic level for New Haven and that's in Oswego County. That will require REMAC approval and also an inspection by myself _____.

Olsson: So what we need is a motion that pending successful evaluation and all the paperwork is appropriate to upgrade New Haven from ILS to ALS.

So moved.

Olsson: Second?

Olsson: All in favor? Opposed? Carried.

If anyone is looking for additional work to do Lafayette and NOCA are in need of Medical Directors, I don't remember what happened to those medical directors _____. And, i.e., -- _____ Dr. Canter is gone to pursue other interests and we'll leave it at that. Lee Memorial.

Unk: Sandy Hargrave is here to give us an update on the hospital.

Hargrave: Sandy Hargrave Lee Memorial ER. At this point in time as it is known Lee Memorial had a 36 person lay-off last week. At this point in time 22 of those people were actually _____. A lot of the _____ patient is the fact that the admitting physicians are moving on from the Fulton area and as they do the admissions, of course, are not there. The ER is still at 100% capacity. Dr. _____ is taking over as director of the ER since Dr. _____ left Fulton, and everything is _____ ED. Admissions just don't make up enough of the difference. At this

point _____ again _____, completely processed for change-over to an urgent care facility. _____, but that's the last _____.

Olsson: Okay, thank you. REMAC committee members. There has been some discussion here and at SEMAC with some of the other regions as to who, what and how is the _____ REMACs. There was a question a while back about representation of agencies and it appears that among the positions that are currently seeking on REMAC, about 80% of the agencies are represented. The composition dates back to the mid-90s or before when the operational guidelines specified 11 positions, each representing a hospital, and that was _____ doctor and that has been carried over. Since that time we've added an ED doctor position who actually is a nonvoting position. The question comes up are we currently happy with this process or do we wish to change it to include position of _____. And so I am going to put this out here for discussion. What's the feeling?

Hogue: This is Troy Hogue _____. REMSCO _____ the by-laws _____. _____. REMAC because it is a voting _____ representing hospitals and _____.

Olsson: Dr. Fullagar.

Fullagar: Chris Fullagar from University Hospital. I think that in the past _____ involved the subspecialty _____. I think we're seeing more and more physicians who either come from EMS or have intimate knowledge of the system and are participating more as medical directors, and we're starting to see a little bit of a change in the role of medical director as someone who nobody ever saw, just wrote the narcotics and now we're seeing more and more physicians taking active roles. I think that the time is right to consider a shift at this point to more hospital representation to physician _____.

Surprenant: There is _____, REMAC, and it is from the by-laws _____ position and also that

the _____ and then also ALS _____ so in the operational guidelines of REMAC that Dr. Fullagar referred to, that's spelled out _____ so if there is _____ go to REMSCO for final approval so I concluded that _____.

Olsson: The current statute limits the number of _____. One of the questions will be is it open to any EMS medical director in addition to who is on here or is there _____. That is something that we have to address.

Witt: This is Therese Witt from St. Joseph's. I really don't think you should limit the number, and I agree 100% with Chris. I am currently interviewing a gentleman from Pittsburgh who actually has his EMS fellowship, he is very interested in, you know, in being involved with an agency as well as REMAC and I think we should welcome his expertise, his ideas and his vote. I think it would really help us recruit all of the emergency medicine physicians to have a really good EMS system. I think it would really help us recruit quality EMS physicians to the area. You know, I just think it's a good thing. If people are willing to get out there and be medical directors, provides CMEs, provides testing, you know, CQI basis, then they should be allowed _____.

Hogue: _____ The Program Agency was run by the hospital _____, representation to the _____.

Surprenant: Right, so basically this group would make a recommendation but then –

Hogue: _____ You would have REMSCO _____

Witt: _____

Hogue: Absolutely.

Olsson: It's once again _____. Actually go back to 1996 to the operational guidelines. So what I think we need to do is to take a look at that, Susie and I, revisit that and we can draft a document _____ that would reword that and by the time that next meeting comes around we could revisit this and potentially have a working document or operational guidelines or policy statement that we can look at and finalize.

Fullagar: I do agree with _____. Somehow build into this a minimum qualification to become a physician on REMAC. _____ EMS background _____.

Surprenant: If you look at the paperwork the agency medical director fills out _____ Dr. Cooney _____ because then if they are approved as an agency's medical director we already know that they've got some EMS background _____ system. _____ approved as an agency's medical director _____. And Warren _____

Darby: That's correct. _____.

Morrissey: John Morrissey, State Dept. of Health. One thing to just remember _____ some councils have kept the numbers small because _____, right percentage numbers to make that _____, so just keep that in mind _____.

Olsson: The operational guidelines for forming a simple majority, and for those who have been around awhile We have several years where 1, 2 or 3 physicians represented REMAC _____. We went several meetings where nothing was done. We actually had a SEMAC meeting a few years ago where we did not have one. So, it can be a double-edged sword _____ define what's a quorum, so _____

Witt: _____ you might ask do you wish to be a voting member or not. If you choose to be a voting member you are required to attend 75% of the meetings, or 50%, if you choose to attend and give

your expertise _____ voting member if you can only attend 1 or 2 meetings a year.

Olsson: We never put a requirement for attendance in the past, maybe we should have. Or maybe that's something else that we can go back and take a look at in the operational guidelines.

Witt: Well, I just think that if we're going to extend the number of voting members and you need a quorum to move forward on issues that perhaps those who vote really need to have some commitment to be here regularly.

Olsson: I agree _____

Witt: and those who choose to participate and not vote, just be _____ members.

Olsson: _____ So anyone is welcome in the door. Okay, we will work on that.

Surprenant: Also, was handed out was a minimum equipment list, which currently _____ and one of the things was asked for was input from agencies in the redrafting _____ so Trumansburg, Dryden and Bangs provided input _____. So what we have included is you can see the existing one, anything that is highlighted is an area is changing or being an addition to and the reason for the highlight is that it's easier to see items, highlight areas that will be changing based on those recommendations from agencies and also from changes in the protocols _____. Cardiac monitor, the reason that is listed is initially _____ so that will come off from ILS and we included it for ILS and the AED. With capnography now starting, that's been included and that will be for all levels that are intubating. _____ suggestion was currently we require a portable in the ambulance, the suggestion was to just _____.

Unk: (_____)

Surprenant: Yes. _____. So far with those changes, is there any comments on those? Objections?

Unk: I guess _____

Unk: (_____)

Surprenant: But that was one of the things where you're going to see some changes on ambulances, that's why I went through _____, the only ones that _____ there goes that piece of equipment left at the scene, and you know I understand the agencies decision _____, but that is my only reservation for putting _____.

Unk: _____ temporarily _____.

Surprenant: Okay.

Unk: _____

Surprenant: That is one of the reasons this is happening at this level is there's _____.

Witt: _____ we go to the scene _____ so we – you may need something _____

Unk: _____

Suprenant: Any other change on those four items? Going on, the water soluble jelly, they did actually have that in tubes or packets the thought was, if they already have them in the portable kit, tube or in the ambulance you need one in the _____ so the suggestion was to decrease the _____ because they have provided it in the portable and in the ambulance. If they carry packets, the suggestion was _____ and it was _____. _____ It's not a high ticket item.

Price: _____

Unk: _____

Surprenant: We had a representative from Bangs, please sign in because I know you guys _____ as well. _____ away so we _____.

Price: _____

Unk: _____

Surprenant: Actually in the _____

Unkn: _____

Surprenant: Yes, going forward in this _____ section there's another _____. Besides what is on there _____.

Unk: _____

Unk: _____ telemetry?

Surprenant: Yes.

Unk: _____

Surprenant: I think maybe he changed the verbiage on that because basically when we're looking at funding, basically _____

Unk: _____ medical control _____

Price: _____

Morrissey: The ability to send an EKG electronically to _____, but the ability to send a wave form. Now _____ for all _____, but I think it needs to be _____, different solutions.

49:36

Olsson: Can we just reword as ECG transmission capability instead of calling it telemetry to avoid that confusion?

Unk: But if it's a State – that's the State verbiage, if that is a State requirement, then no, we can't change it.

Morrissey: If you want, I can go out and read the law, it says the ability to send, and I've forgotten the phraseology of it, but I think you're right, telemetry is the word.

Surprenant: Transmitting device?

Morrissey: Let me go to my truck and go pull it. Troy, do you have it?

If you want, I'll run to my truck and get 800 and read it, because I just don't have it memorized.

Olsson: I think that if we could change, we will, but I'm going to bet you that's the way the State has it written and we're stuck with it.

Morrissey: Let me look. Shall we get rid of the requirement for ILS to carry that since it's _____.

Surprenant: Good point. You can safely take that out for ILS.

Thompson: Just kind of a procedural question, this is Dave Thompson. Just a question about that? It may be a State requirement, but the cost of actually acquiring it and the cost of having John actually prove that it works, whoever, Susie or whoever evaluates this. I'm not sure how many of those devices are actually available out there at this time. I wonder as a region should we put that there, if the State wants to require it, that's fine, but as a region, I don't think it's an useful device.

Unk: How many of our EDs have the capability of receiving telemetry ECGs.

Olsson: That's not the State's responsibility.

Morrissey: Right.

Because the assumption is the ambulance could go places that don't -- that aren't from the local region. There are some regions --

Unk: But the ambulance is going to have to demonstrate in order to be licensed that it can send -- successfully send, which means that somebody is going to have successfully receive so you can't -- you know, the region can't certify an ambulance with this requirement unless we've got sending and receiving. It's just gets us into a hassle, if we just take it off because nobody does it. If the State wants to enforce it, John, I mean --

Morrissey: How about this. This one has been around so many different times at State Council and so forth, I would have to call Albany and get a more definitive read and give you the absolute read. The question does come every so often, and I pull out 800 and read the statement in there, that it has not been repealed, _____.

Price: There are agencies who are using it. Colleen Price. I work for an agency in the southern part of the region that it is an expectation with the _____ with the hospital. They have the capability and it is expected that they will send telemetry. It is not an option. We will send an EKG with the patient's _____. So there are places in our region that it is done.

Thompson: This is Dave Thompson. But it's a difference between whether you require it or you do it. If you can do it, that's fine. You could carry, you know, full cardiac monitor defibrillators and that's fine. This is a minimum equipment list, and if we require it as a minimum, then everybody in the region is going to have to have it and demonstrate that it works.

Morrissey: If I could, let me just read it and I'll paraphrase here quickly. It is the 800.5, first off it says have a designated qualified physician provide medical supervision, and it is integrated with the hospital emergency service, intensive care, coronary unit or appropriate hospital unit. The ambulance will provide advanced life support will meet requirements of 823.4. Then it says, advanced life support will be provided prehospital or immediate must have the following: Voice communications

receiving medical direction, then it goes on to list the other things. Then it comes back to say advanced life support providing prehospital critical care or paramedic services must include the following: Voice communication receive medical direction is number 1. Number 2, bio-telemetry. Number 3, supplies provided and so forth. That is delineated in the code. The enforcement aspect of that and how that would work out I would have to seek guidance _____.

Thompson: So the hospitals better get that equipment?

Morrissey: I didn't say that either, Dave.

Markham: Joe Markham. I have a question. I wonder if they would meet the standard of the State as the agency could send a 12 lead EKG to one of their systems _____ if we would still meet this standard.

Olsson: I would interpret that as yes.

Markham: So maybe we could solve this by saying telemetry or EKG.

Surprenant: It's the same.

Olsson: I think the simpler way to do it is to leave the terminology on this form and then we can as a region define in our own words what that means, and I would interpret that as any way of sending any kind of information other than voice. I don't care how you do that. Wants it by mail, carrier pigeon.

Unk: Then I do think that we have that capability now because a lot of agencies are using 12 leads and a lot of hospitals when they upgraded their radio systems have not purchased equipment to think telemetry, but they have invested in the fax machines that they can receive these EKGs so I think that we are meeting the spirit of what the State would like, that's what I would think would do that.

Olsson: I would, and I don't want to get bogged down on one thing at number 4 so I think that we are well within the spirit, we're doing it and I feel that everybody is obtaining it with this regard, too. Move on.

Surprenant: In this area, it was LMA, now _____ was since they weren't used a lot that basically they were collecting dust in the portable equipment, the ambulance and back stock and they were expiring, and it was costly so I think would refer whether we had LMA _____ between any secondary device, if they have it in the portable kit _____ ambulance, do we need the back stock of that?

Lyng: John Lyng. Just as a point of clarification, do we want it to be a specific _____ tube or are we considering other non-_____ airways like the King LT --

Surprenant: It is specific in the new protocols, LMA is replaced by Com-V. We did have that discussion with King and that was not in there, but I think King can be another discussion because King packages, their airway has an laryngoscope, not as a secondary airway device. I think this would hold to another discussion. I mean we are not going onto what we have approved for the protocol and King was not.

Olsson: So basically as we move on, there's going to be more products to do the same thing and right now what we have to do is we have to tailor this list to our current protocols. Down the road we will most likely get to the point where Com-V tube will be replaced by an alternative airway device, and then it would be up to the agency and the agency medical director to decide what that airway device is and then we can change this, but if we start changing this now to airway device, now you're going to confuse the protocols so let's try to keep this current list consistent with our current protocols and then once we become more liberal in our future description then we would change it.

Cooney: My personal opinion on this is that you're already carrying 2 large and 2 small crash emergency airway alternatives and that should be plenty.

Surprenant: I mean that's – the other thing that is not included is the RSI piece because we're at the point where we just have put the policy statement, the training piece has got to be done, and then the agencies, the providers that will be using that, so you're right we would have to update that when that's in place as well. So does this group, and we'll just keep generic. Any secondary airway device, are we going to require them to carry the back stock as well?

Lyng: What are we defining back stock is?

Surprenant: That's what in their stock room. So they would have 2 of each size on every rig, but they wouldn't have any in back stock. So when they get down to the minimum they still have to find it somewhere. So if they have other ambulances that are their secondary they can change it and that rig doesn't meet the minimum or they have a quick supplier that can turn it around quick. It's going to be up to the agency --

Lyng: _____ back stock.

Surprenant: This is just the minimum. So there are some agency that states you know what we're going to use it. We went ahead and had a discussion at the last meeting or 2 meetings ago about laryngoscope blades and there was one suggestion saying that we should have a full secondary set and there was another suggestion that we need a _____ set or do we leave it as is.

Markham: Joe Markham. I think that we should have a full set in the ambulance because some patients _____. I think that you need a full set in the go-bag because that's there you get intubating sometimes in the house, and this is mandatory advanced life support equipment. I think that wherever you are going to do the job you should

have the right equipment, and you shouldn't have to go into a go-bag when you are working in the back of an ambulance. So I thought that it should be a full set in my opinion and also we should include an adult and pediatric Magill's and I would also suggest that we keep at least 1 CO2 detector in the go-bag because if somebody gets intubated in the house you could be at least 5 minutes or longer, sometimes 10 minutes before you get them in the ambulance and put them on the wave form capnography. That's a little bit too long for somebody to go without proving that you've got a good airway.

Price: So the suggestion was for the blades, another full set in the ambulance.

Thompson: This is Dave Thompson. You've got less -- with all the blades that you've got here that's less than \$100 to keep all those blades, and blades do break unfortunately. There have been some recalls recently and things like that so I think it's not a bad idea to have at least some redundancy out in the field.

Unk: _____.

Why do they?

Morrissey: The other thing I might add this came out of a suggestion, because people leave airway bags on scenes and then they have nothing and that's why I suggested another set.

Thompson: I think the ambulance should have a set of Magill's because if that is where you need to use it you shouldn't have to go fishing for the separate device plus you could leave the airway bag at the scene.

Surprenant: So I hear a consensus that we should have another full set of blades and then another set of Magill's adult and peds in the ambulance, and Dr. Markham for the end-tidal would be instead of the ambulance, have it in the portable kit.

Markham: Yes, we're requiring a wave form in the capnography so that should be able to replace that. I think you should still definitely have the disposable end-tidal CO2 detector in the go-bag.

Surprenant: So we can change it for the kit will have 1 and then the ambulance would have 0.

Lyng: The same should go for the esophageal –

Surprenant: EDD, yes, correct.

Susie?

Surprenant: Yes.

Unk: Dr. Markham, are you saying that – Susan Flynn from Tompkins County CQI. End-tidal CO2 in both ambulance and --

Surprenant: No, it would only be in the probable kit, nothing in the ambulance because capnography would be in the ambulance. For the ambulances that are going to have capnography and most likely will have it, but understand if there is a failure with capnography and you're in someone's house or out in the field you can grab what's in your bag, but the ability with capnography, what SEMAC had said is that end-tidal CO2 detectors and the EED's would be a back-up to that so that would allow us to reduce what's in the ambulance to 0 and then would just basically shift it from the ambulance to the go-bag.

Unk: So you would have one or the other?

Surprenant: They require both, but then we're just moving it from the ambulance to the portable kit.

Olsson: Isn't that standard for the protocol? I thought we changed that.

Surprenant: No, that was _____ the EDDs were not _____.

So we're going to have just in the ambulance not in the portable kit.

The other way around.

Wallis: Can I ask a question?

Yes.

Wallis: Norm Wallis from Oswego County. If we're requiring capnography for all intubated patients, why wouldn't that be a piece of equipment that goes to the patient's site.

Surprenant: It would be because they have a portable or if that fails then that would be in your portable kit to use right away.

Wallis: I understand.

Markham: Most of the time in an ALS ____ goes to a call, it's an ALS call, they take their monitor with them and it's often that monitor will have capnography on it, but some agencies may be purchasing a separate wave form capnography device that is either fixed in the ambulance or the site of the ambulance that maybe it is not convenient to carry it into the house, if they took it right into the situation where you're intubating away from the ambulance, there still should be some way to make sure they have good airway until we get them on the wave form. Most of the time I think that they're going to have it with them because most of the ALS times they grab their ALS bag and they grab their monitor and most of the monitors in our region now I believe are 12 -- are Life Pak 12s which many of them will have the capnography on it so that will solve that, but if they don't., they don't necessarily have to have that equipment.

Unk: So that's what I figured, it would either be on the monitor or it was going to be a small portable unit even though there is going to be other fixed units.

Surprenant: Susie Surprenant, the agencies –

Markham: ___ in the ambulance where I can envision it's not easy to grab because you have a monitor in one hand and the bag in the other, but the capnography device is separate, at least you still have something.

Surprenant: The agencies that I talked to that are going to have the portable units, they would have them with them. If they're small enough they've got capnography SPO2 monitoring and they're small enough to carry in their O2 bag and they would carry it with them.

That would make sense.

Surprenant: But in case one of those two devices, whether you have a portable unit for capnography or monitor, if that fails and you're in the house or away from your ambulance you still have the ability to grab what's in your bag.

Great, and I also agree with that, too.

Surprenant: And that would allow us to reduce what's in the ambulance since that's not our primary device any more, but it's just a back-up to the capnography.

Price: So the squeeze ball device for EEDs are going to be --

Surprenant: Yes, 1 for portable, 0 –

Price: No, I'm asking about specifically because it says rim style _____ because there is a lot that are bulb syringe type.

I thought we weren't suppose to use bulb syringe –
_____.

Price: So I guess syringe is staying.
_____ style, right?

Yes.

Surprenant: Quick-Trachs, the same suggestion was the same with the secondary airway devices since they're not used that often, can we decrease what's in the back stock to 0 like we did for LMAs? So they would still have them in the portable kit, they would still have the back-up in the ambulance. Okay. Suction catheters, a suggestion was to decrease what is in the back stock since the agency has it in their portable kits, has the other device in the ambulance do they need to carry that many suction catheters. The Yankauer tips are used frequently, but the actual 6 and 8 French through 14 are not used that often. I don't want to decrease what's in the ambulance because what I found over the years is usually they are stuffed in with the suction, if they get a kink especially with smaller ones they're useless so I prefer, my preference is to keep the back-up in the ambulance in case of that.

Markham: I have a comment here. I am a little concerned about this, the back stock of suction because that is a device that is used a little bit more frequently. I understand the Quick-Trach Device would not be, but suction is, even the different sizes, and I think to be roll back out the door and have to use one you should have another one ready. I think that you would need at least one of those in back stock.

1:08:50

Morrissey: John Morrissey with the State Health Department. The 6, 8, and 10 French are required at 2 each so if they use 1 during a call, in theory they need for certification anyway --

They need at least 1 back-up?

Yes.

Surprenant: So switch all those back to 1.

Unk: _____ I'm not understanding how we can drop any of the back stock _____, I'm sitting here quietly, but so if we do a call and use one of these

devices, then you don't have 1 back in your station, the ambulance is out of service until you ____ is that my understanding?

Unk: If it's a minimum, if this is really a minimum for us --

I'm referring to _____

Unk: If I'm saying that if this is really a minimum, that as an agency I have agreed to this for the privilege of practicing, on any one of these devices where we say there is no back stock, and I use 1 of them, then I no longer meet the minimum, and I have to wait for an order to come in?

Markham: So they're going to have no back stock. If you have the ability to restock right away, ____ you might be right next door to ____, you might get stuff from the hospital. There may be different ways that you order. If you order like in mass ____, it's different for you, and there may be some agencies _____.

You would get the catheter at the hospital.

Right.

Okay.

Unk: I think that TLC is one of those agencies who try and restock at the hospital, is that still the practice? Down in Cortland?

Not after the 7th.

Okay.

Markham: But that is still a possibility. If you're in that situation, you've got to have the stock because you can't roll out an ambulance without the minimum.

Cooney: Right, like one of the combi-tubes, if you use a combi-tube, the way we've set this up, you know, one in the portable, one in the ambulance and

no back stock, and those are the minimums you're saying for us to practice in this region so if I use one and I don't have any backup at the station, then the ambulance is out of service until -- if I don't have them back at the station --

Surprenant: If you look at our existing -- when we get to the medication list, the current existing has what is in the portable kit, has what in the ambulance, when I was going through this, we basically don't require anything in back stock, 0, in medications so since this policy statement has been out since '01, it has required no back stock for medications.

Lyng: I'm not getting it.

Cooney: This is Derek Cooney. I just have one thing to throw this whole back stock discussion, if you have a minimum number and you go back and you use it at the station to resupply the ambulance, now your service is out of service, that doesn't make any sense. Back stock has nothing to do with whether or not an ALS unit can be in service. It might as well be 0 for everything in the entire column if it's going to be a minimum required equipment for the operation of the ambulances, so that wouldn't make any sense. Now I was suppose to have 2, now I've used 1 and I only have 1 in back stock, my ambulance is now out of service, so that doesn't make any sense so we should probably consider that column something different. I understand the new requirement on the unit and the provider. The back stock issue is getting really kind of unusual.

Surprenant: Your point is basically why worry about the back stock because this is how much is in the ambulance, this is how much in the portable kit, that's what you need to stay in compliance, then it's the agency's responsibility to determine how much they carry.

Cooney: Right. We don't care how many you have in back stock because we just carry what's available _____ That's what we care about..

All right.

Surprenant: Since this is a big change, can we have a motion to eliminate the back stock and leave it up to the agency to determine that they will be in compliance with the minimum equipment list for what's in the portable equipment and the ambulance, and it will be up to the agency to determine what they need in back stock to keep in compliance, and that may be a supplier, that may be another ambulance, we will leave it up to them.

Olsson: Dr. Fullagar, you're agreeing to the motion or do you have a comment?

Fullagar: I make the motion.

Olsson: I don't know if it will require -- if it is necessary for us to include language in there, something along the lines of, it will be expected that the ambulance services will maintain a sufficient back stock to adequately keep their ambulances stocked.

That could be part of the motion. Is that okay?

Fullagar: I amend the motion.

Okay, seconded. All in favor?

Olsson: Opposed? Carried.

Surprenant: Okay, so that means _____ podium. 14 gauge needles used for chest decompression, the suggestion was to take 4 in the ambulance down to 2. I guess that we don't use it that often in this region.

Lyng: Question on that. I shared some literature about the _____ and not being successful at 2 inch versus 3 inch, 14's, I don't know if that is a consideration or not.

Price: Do you want to share that?

Lyng: There are 2 studies, I forwarded onto you, and I think 2 were military and 1 was civilian --

At least.

Lyng: That talked about chest wall thickness and especially in females that you needed longer catheters to be able to effectively decompress the chest, and the standard here for years has been 2 inch, but as I think about that over the years, there have been a couple of times where people have had to do 2 catheters and so forth to get _____. I am wondering sometimes if our catheter was the issue, not necessarily -- but after reading those studies, but I don't know if they were good medicine or not. That's why I forwarded them to you guys for review.

Any comments?

Flynn: Susan Flynn from Tompkins. Do you know where -- we have a hard time just getting the 2 inch unless we shop around for a different manufacturer because our hospital doesn't supply them. I have never seen one advertised that _____.

Morrissey: In JEMS, a few months back, they had a handout, kind of these military ____, I can get you the address, and somebody else help me if you can remember. They had the studies in there and put it out and they sell the catheters. They are on _____. Apparently those catheters were issued to all military folks within the war zone. They are taught how to decompress along with the tourniquet thing as another standard that they deployed ___ and that's where the study came out about the 3 inch catheters, but they are available.

Thompson: This is Dave Thompson. I would agree with John. I think the longer ones, you're not going to do more ___ in this patient having a 3 inch versus a 2 inch. I think that the idea of decreasing the stock was a great idea.

Okay.

Fullagar: This is Chris Fullagar from the University Hospital. I do recall some studies that have actually looked at this, in particular, looking at chest decompression which was done which revealed at autopsy, if I recall correctly, up to 50% did not even penetrate the chest wall. I think that this is a vital procedure that we do, a lifesaving procedure, especially for the agencies that have long transport times. As far as the length of the catheter, there is not a lot of _____ second intercostal space, so you're really going to be getting into too much trouble there, and I think the extra inch so to speak may _____ in some instances especially _____.

Olsson: Do you want to change that to 3 inch?

Surprenant: ____ to keep that.

14 gauge 3 inch.

Price: And then 2 in the portable kit and 2 in the ambulance. The question ____ 14 we still need those for IV fluids, that's coming down the road. (_____).

Surprenant: Okay, next. The second line, there is no changes on that. 1,000 cc bags of saline, the suggestion was dropping the ambulance from 4 to 3.

Where are we?

Surprenant: We are at 1,000 bags of saline.

Markham: Joe Markham. I was looking at this whole rest of the page, and I don't see any real value in changing these numbers. I can see that there is, you know, saline, you can go through a lot of that easily. You don't want to run down to your last bag. These things aren't particularly expensive. As far as IV sets, I have been involved in several patients where we've gone through 4 attempts at IVs so, you know, I don't, I would say the rest of the page leave it right where it was would be my opinion.

Surprenant: Dr. Markham's suggestion is to leave things that are highlighted, the original numbers. The only thing that I would have to add is the 3 way adapters, we took out of the protocols, and I did not see any medication that we would mix in a 100 cc bag any more, that's the only reason those are _____.

(_____)

Versed has to be in 250.

Surprenant: It's 250.

And what do we use the 250s for?

Surprenant: Some of the agencies do now have that treatment and some do not.

Cooney: So is there a way to say you can have A or B instead of having to stock these _____

Absolutely.

Could you say 250s for drips _____.

That would work.

Flynn: Susan Flynn. I know Dr. Markham said _____ talking about the administration kit leave it that way.

Which one are you talking about?

Flynn: The _____.

IV drip sets?

Flynn: Yes, sir.

1 in the go bag, 2 and 4 in the ambulance.

Flynn: It says 3 for micro to change to 2 and 3 and macro.

The original was 2 and 4, right? I'm sorry I'm looking at the wrong line. 4 and 3, again I wouldn't mind dropping it down to 1.

Flynn: You could drop it down by 2. Micro drips, I mean we use them for medication drips.

That's it.

Flynn: Macro drips, yes, we keep 4 on our vehicles, never go through 4 of them only because most of the time our IVs, or a majority of the time the IVs are saline locks, not requiring a bag so we really don't go through that many macro drips, and we have them other places on the vehicle because we tend to overstock rather than understock so I mean the micro drips when you think about it, if you keep them up, and I know that it's not that big a deal, but \$5 or \$6 per drip set, if you don't use and that's what we pay for them.

Surprenant: If you look at the macros, if you are to include bolus, all you're doing is switching off the saline bag not the drip.

Flynn: Correct, you're not changing the IV tubing, you're changing the bag, and you may possibly go and do 4 calls in a row and use 4 macro drips, but we always have back-up anyways so --

Surprenant: So what was your suggestion for macro and micro for the ambulance?

Flynn: For the ambulance, I think the micro drip can be done to 1 and the macro drips can still stay at 3, I mean we're not gaining much by 3, but we could go down by 2.

Surprenant: Brian Calley?

Calley: Brian Calley from TLC. Just from a standpoint of this discussion this evening, let's keep in mind that the reimbursements and medical economics and so on that have occurred, times are getting very difficult. By reducing the macro drips, and I want to use Susan's number of \$5 a piece by 1

over 10 ambulances that is a \$50 reduction in what we have to put in equipment. The numbers on this list seem very reasonable to me. Again, it is getting more difficult every month to continue to buy this equipment, the price of equipment goes up, insurance goes up, fuel is down, but we're going to get beat some place else because now the budget is going to get slashed. That not only affects the commercial providers, but it affects the non-for-profits as well as the volunteer agencies for the EMS services, fire services. My opinion is that the slimmer we can make the list from what we are carrying on the trucks the better.

Markham: Joe Markham again. My feeling is that I wouldn't disagree with the micro drip to just taking that down, I would say 2 right? I have just a feeling that, you know, the way that things work in the field, it's very easy to drop something on the floor and you really should have a back-up for something that it is important. The macro drips, you can usually put 2 IVs in a patient, that leaves you 1 left on the rig, if you go down to 3, that's cutting it pretty close I think. Again, if you drop one, you use two, then you have none left. I think that we're talking about a relatively low cost here, and I agree absolutely with what Brian said about cost saving. I think that is very important, but patient care has to override that.

Morrissey: John Morrissey. I might just remind everybody that -- let's not forget that we can have double the trauma patients, where you are going to have 2 trauma patients now in the back and back-ups for macro drips might make some sense. The other thought I'm going to offer, too, I can envision a code, where if you do dopamine and lidocaine, okay, there goes 2 of your micro drips right here, and if you have to do mag or some, you know, it's a heck of a code, but my point is that you need some extras, and these are cutting very thin.

Surprenant: Dr. Lyng.

Lyng: John Lyng. Has anybody in the region ever given a thought to developing any sort of buyers

consortium. Coming from North Dakota, there is a northern regional buyers consortium, where an ambulance service can become a member of it and they end up working with other squads in the region to purchase similar equipment, the disposable type of equipment and because they are purchasing larger amounts or larger quantities, they went up getting bulk rates instead of one ambulance service ordering 15, another ambulance service ordering 15 and spending more for smaller quantities being ordered where if there is a buyers consortium developed some way or another some costs, some money can be saved that way. And things for like IV catheters and drip sets and things like that that are pretty simple and standardized to some extent, that could be a good thing to do.

Price: Cortland County has not been terribly successful.

Olsson: So what do we want for a minimum here? The macro drip, the micro drip?

Markham: I think that we should leave it where it was.

Surprenant: So your suggestion from 1,000 cc bags all the way down to 24 gauge cath, leave the numbers the same?

Markham: We agreed to have the 250 bags along with the premixed solution for _____?

Yes.

Markham: The rest of it, yes, I would make that recommendation.

Any other comments on that?

Thompson: This is Dave Thompson. Just as a comment about the whole procedure, I think that one of the things that we ought to be expecting is that service CQI looks at what their par levels should be, and while these might be minimums, I think we can even drive these minimums lower as

long as we have some sort of a requirement that services review their par levels to make sure that they are not running out of important equipment. You could say that you only need to have say a total of 4 macro drips between the portable kit and the ambulance as long as your CQI consistently looks and says that more than 95% of the time that is more than we are using. I think that is a very reasonable way to do it that is cost effective for programs and agencies and serves the patient as well.

Flynn: Susan Flynn. With EPCR does the agency use the supply section of that?

Unk: No. I keep inventory. I do the restocking, I do the re-ordering. I understand what Dr. Markham is saying that patient care is the ultimate goal here and I don't disagree with that, but as Brian said because of the reimbursement I know that our agency has 11 vehicles which can be costly, but we also went to other things that would be more beneficial to the patient, auto pulse, IO needles which is not a billing purpose, there is a maximum that we can bill for so what we may not be keeping in stock as far as micro drips, catheters, bags, we're helping the patient in other ways, also.

Cooney: I think what, correct me if I am wrong, but Dr. Markham is _____, high volume use, low cost items, and just like you have family members in your family and think that they are saving money by filling up their tank when it is empty rather than when it is $\frac{3}{4}$ tank full and you persistently pointed out that they are not using any less or more gas, it's the same issue with low cost, high volume items. So if we leave these numbers high you'll have no additional cost and keeping your rig in service, you use what you use. The only issue is for installing new ambulances, and again I think we're talking about 5 or so dollars each unit, and there is a good clinical reason to have multiple things at a minimum _____

Unk: One problem with that is that almost these things outdate, and if you were to have 4 of a given

thing and maintain your stock, your back stock is going to have some substantial number to maintain 4, it's going to be larger than if you only need 3 or 2. These things that outdate, they get outdated before you actually get to use them in some services and that's where the cost comes in. It's not just starting a new ambulance, it's just the things expire, and some things expire rather rapidly.

Lyng: Just there is some cost associated with increasing frequent orders to replenish your stock. If you're running through your stuff pretty quickly and having to put in more orders for --- instead of ordering --

Olsson: We can spend the whole night just discussing generalities and unfortunately that's not the task that is in front of us. We have a minimum equipment list. If your agency is busy and you're running calls where you can't possibly or you have to more than this, you have more. We're looking at what's the minimum for the region and that goes down to Tompkins County. It goes up north so some how we have got to come up with a garden variety basic minimum to keep an ambulance on the street. Are we talking about the macro and mini drip still?

Surprenant: Yes. We're in that whole section from 1,000 cc down to the 24 gauge cath.

Olsson: All right. We've been on this now for almost 15 minutes so we need to wrap up this section one way or the other. Dr. Markham.

Just a brief question. What was the initial reason for reviewing the minimum equipment list? Is it to try to get some cost savings for the squads?

Surprenant: Change in the protocols, additions to the protocols and then also some cost savings to the agencies, especially on less frequently used pieces of equipment. Dr. Wirtz?

Wirtz: Dave Wirtz. I think that as a group of physicians it's our role to mandate protocols and

____, but I think if the EMS providers in the region think that they only need 3 of these catheters we should _____.

Markham: I'll make one last comment here. I think our responsibility is to make sure that there is at least enough on an ambulance for 1 call. What is the one call that is going to require the most of that particular type of problem. Whether you are a high volume or low volume agency, you may still get that one call where you need to use all of these things so that's where I think we should be thinking about what is the minimum list. That's where I am coming from.

Morrissey: Again, to be quite honest I don't know of many agencies that stick right to a minimum list anyways, they probably throw a few extra of most everything on there. Where it gets frustrating is like we put trachs _____ that's where it gets costly.

Olsson: Okay, so if we look at macros and minis, every ambulance if they've got 3 macros and 1 mini, they can take care of at least one patient if not two. If then if agencies want to carry more than that, great. What else?

Surprenant: If you look at 1,000 saline, the total is 4, that would take care of 2 patients because we're not suppose to infusing more than 2,000 cc for fluid boluses.

Price: A total of 2 bags _____

Surprenant: That's the way it's written right now, that would offer 2 patients to be taken care of. The 250 or the pre-mix, that allows for 2 pre-mixes, the same with the 50 ---

Price: Which means the pediatric stuff, that's why we're keeping it _____

Surprenant: So we either live with what we have or accept this group with the changes.

Price: You have 4 bags of IV fluids and right now if one of your tubings gets contaminated or dropped, you're S-O-L. That is exactly what you need. You have 1 tubing per 1,000 cc bag_____.

Surprenant: So your suggestion is to change that back to 4 and leave the other stuff as it is?

Price: I think you have exactly what you need right now. There is _____

Surprenant: I think that's the goal of the equipment. I know a lot of the agencies are carrying more than that. Can we live with this the way it is from 1,000 cc down to 24 gauge caths? Going once, twice. All right.

Price: Can I suggest that the 14 gauge be specifically the short there?

Surprenant: Yes.

Price: That makes it an inch and a half?

Inch to inch and a half.

Surprenant: I O needle for adult, that was added because, with an asterisk after it, because that is now part of the protocols, and so that would include like the EZ-IO, the ___ or the fast, that's not mandated, that is why there's the notation after that. Disposables razors, it was suggested 2 and 1 versus _____. Alcohol preps. I think I remember counting 12 for quite a while. Neosporin, I don't know how many people that start IVs are using Neosporin or use it on a 2 x 2 on a lac so the suggestion was to do just 12 and 12 and then Neosporin 6 and 6. Stay with the same concept with the Band-aids. Padded board splints. There are some agencies that are using splints when they want, instead of a padded arm board. The suggestion was taking the 9's off because you can take the 18 and if you need a 9 you just cut it in half. I don't think there is a high use of padded board splints. Can we live with what is in the alcohol preps all the way down to 18 inch?

Markham: The padded boards you use that for peds and if you have an 18 inch one, the only ones you use you really cut in half. If you're going to have a kid, you have a 9 inch so you can strap his arms down.

Price: Are you talking about the difference in the width of the board?

The length.

Surprenant: I understand. The 18 boards can be 4 inches wide, whereas the 9 inch can be 2 inches wide.

Unk: I think I would leave that.

Surprenant: Leave that. 9 inch is 1 and 1. Is the rest okay on that? Moving onto pediatric EKG electrode sets. Instead of 2 and 4, 2 and 2. I'll discuss benzoin. The benzoin, the interesting thing when I go to spec agencies, whether it was for adding a piece of equipment or compliance issues or inspections, the interesting thing there is not a lot of people that know that that is part of requirement list until I tell them this is what I'm going to inspect, because have all these items in place. It's amazing how many agencies don't even realize that that's part of our requirement. So that means that the suggestion was you've got a bottle in the ambulance or you decide to use the pads instead. The thought was to decrease the pads.

Markham: Why do we require pads in the ambulance and not a bottle?

Price: Because some agencies want the pads and not the glass bottle I believe.

Markham: The pads in the ambulance --

It's either or. They don't have to carry both.

What I'm saying it's not consistent here.

Surprenant: And there are some agencies that don't even have this to be honest with you. There are a lot of agencies that -- this has been in this region as long as I can remember. So is there a value to even keep that?

Morrissey: Adhesives years ago weren't that good.

(_____)

Markham: So get rid of the benzoin?

Surprenant: Yes. All right. Okay, so we go down to tablets are still the same. Adenosine, since we no longer have the back stock should be 5 and 5. So that the 0 for the ambulance needs to be changed to 5.

Price: That's what I was looking at the top and it's still listed.

Surprenant: Right, but we are going to be changing it to an elixir so that protocol with acetaminophen and Nubain is no longer going to do that. So it will be the elixir which is the --

Price: It needs to read that way, right?

The acetaminophen is optional.

It is an optional protocol.

(____) it should be under that list.

Surprenant: What I'm saying is that protocol is going to disappear, but in the new pain management is on the left side of the algorithm. There is acetaminophen elixir so what we need to do is put the asterisk after that where it references that it is an optional piece of equipment. To change it to the elixir.

Price: Like the dot, dot, dot.

Surprenant: Yes.

Price: Okay.

Markham: I have the same issue here as I mentioned before in some of these issues --

Surprenant: We're going to switch them.

Markham: In the ambulance, I don't think you should 0 in the ambulance that you have in the go-bag.

Surprenant: Adenosine will go back to 5 in the ambulance and 5 in the kit, so there are a couple that are O's that are going to have to go back the original numbers. So Adenosine will stay the same. The suggestion was for albuterol to do 4 and 2.

I think we should leave that at 4 and 4. It's a medicine that is used a lot. It's a vital medicine.

Surprenant: Change that back to 4.

With the adenosine, you've got 10 total available to you.

Surprenant: So you're thinking less in the ambulance --

Witt: How far are you that you're going to use 12 --

Surprenant: Technically if you go through the whole protocol, they're 6 mg vials, you're going to use 5 so your suggestion is have a few in case you break something?

Morrissey: Hopefully you're not standing ---

Witt: That's my thought on all the micro drips and things, like how long are you going to be in the field.

Sometimes they are long.

I've got a 30 minute transport.

(_____)

Surprenant: So when I look at meds, how many do you need to run the whole protocol, you would need 5 of them at the 6 mg, but what you're saying is reduced the ambulance stock in case 1 breaks, 1 has expired.

You've reduced part of the stock with the other. I just think it should be 10.

Markham: We don't need 10 on any call, but if you take a bag in the house and you're in a situation where you've got it running right there, you need 5.

Unk: You need somebody else with you. You need somebody that can run to the truck and grab the other ones. You only need 1 or 2 in the bag to get you started and hopefully you get butt out to the truck, but if you can't you get somebody to grab them for you. I mean you don't need to carry a lot of glass vials in a canvas bag --

Markham: I've done calls where we're out in the field, 100 to 200 yards from where you leave the vehicle. A go-bag is to go. Okay, you need to be able to be away from the ambulance and manage your stuff. I also think you should be able to manage whatever you have with an ambulance stock despite your go-bag.

Unk: Adenosine is not one of those -- at least in my experiences, it is not one of those drugs where I use more, if I use 3, if I use 6 and then I give 12, and I'm unsuccessful --

Price: I move on.

See we have other choices that we do. EMS doesn't.

But if it's unsuccessful, it's not going to be any more successful using --

I won't disagree with you there.

(_____)

Witt: But as a medical control director, if they've used 6 and 12, and have gotten no effect, I'm going to ask them to cardiovert. I'm not going to ask them to use more Adenosine, I'm not. It's not right. It doesn't work. It's over.

Unk: _____ and if you have a couple in the bag and 5 in the truck, you've actually got more.

Witt: Why not reduce it to 3 and 3? Since that -- how many people here would use more than 18 mg of Adenosine.

Unk: One other question, how many people are going to leave their entire ambulance bag behind and keep driving.

It happens. You'd be amazed. _____.

Cooney: I've gone back for my drug bag.

You don't figure that out until you're half way to the hospital.

Surprenant: Colleen Price.

Price: There are some areas where sometimes a medic may be responding in a vehicle by themselves. It may be 20 or 30 minutes before transporting _____ when you say you need to have somebody with you that's great, but a lot of these agencies just don't in the rural areas. They have a medic who is going to show up.

This is only transporting vehicles.

Price: I understand, but a lot of these transporting agencies, you get into some of the rural ambulance services, they have a medic who is showing up and there is somebody coming with an ambulance, but that transporting vehicle isn't going to be there --

Unk: We're also talking about a minimum equipment list and if your service is in a situation routinely where you have greater needs for some of

these devices or some of these drugs then by all means you should carry them, that is not what a minimum means. A minimum list is going to get you licensed.

Witt: It gets you started. It doesn't keep you going for 2 hours.

Unk: I think for adenosine if you want to cut back, I wouldn't disagree with 3 and 3.

Unk: I think 3 and 3 is reasonable.

Surprenant: Albuterol is staying at 4 and 4. Aspirin will be 1 bottle and 1 bottle. Atropine 3 and 3. Cetacaine 1 and 1. Dextrose 2 and 1.

Price: You said Cetacaine is going to be 1 and 1?

Surprenant: Yes. All right. Benadryl 1 and 1. We're only able to give that once in the protocol. Dopamine that is to go 1 and 1.

Is that a pre-mix?

It can be either.

Either/or.

Either/or.

Surprenant: Epi 1:1,000 2 and 1.

Markham: Why are we doing less in the ambulance?

Surprenant: Two doses per the protocol max so you're 1 in the ambulance, 2 to be your extra, if you ampule incorrectly, drop it, or do you want 2 and 2 to match it?

Markham: I think that some people here disagree with me, but I feel that everything you need in the ambulance, everything you need is a minimum, the go-bag should be the extra set.

If I had a choice one way or the other, that's the way I would do it.

Surprenant: So Dr. Markham's suggestion for Epi 1:1,000 is to keep it at 2 and 2. Epi 1:1,000 30 ml vial needs to be 1 and 1.

Price: Is it 2 and 2? Is there a consensus?

Surprenant: 1:1,000 30 ml vial that can be 1. The fentanyl, that is written that way because according to the policy statement we only can carry 200 mcg of fentanyl so that mirrors --

Markham: So why don't we put the 2 in the ambulance and 1 in the go-bag.

Surprenant: Well, it's going to be wherever the red box is.

Markham: Okay, which will be on the ambulance.

Surprenant: So mirrored that according to what is stated in the policy statement.

That is going to be in the lock box which resides in the rig, should you shift it over put in the ambulance, not the go-bag column.

Surprenant: I think we'll have to do that for all of our controlled substances then.

Markham: I think it could be in either spot. Generally most lock them in, but I do have some that lock them in their drug boxes. But generally you're right _____.

Surprenant: What we can do for the controlled substances on the last page is just say can be stored in either the ambulance or the portable kit, depending --

Markham: Put an "or" in there, you could have a full dose in your go-bag or you have a full dose in the ambulance, but you don't need both. Okay. Then _____ decide how you want to do it.

Surprenant: All right. Colleen, so what I'll do is switch or for anything that is a controlled substance. Metazonal, we will need 1 and 1 again.

Does anybody ever use that?

Witt: Does anybody ever use that?

Surprenant: I was hoping that in the next protocol revision that we will have more especially with EPCR we will actually be able to say okay no one has used it in the last 2 years. That may be some of the benefit of electronic PCR is we will be able to query those things and find out which protocols are being used and which aren't. I anticipate that --

Markham: _____ if you give a medicine that is reversible, you probably ought to the reversible agent. If we give a benzodiazepine, I don't know if we're actually going to carry it, now if there is going to be a problem, that's thought there.

Morrison: I also have had cases where the patient has overdosed on 1 medication so it wasn't -- I didn't give benzo _____.

Witt: _____ you're not suppose to give it because they can seize.

Cooney: I question whether it is more a liability to use put it on an ambulance, but that's a protocol question and not a minimum requirement, right?

Markham: Well, I would put it in the ambulance - - well, again put in more, let the agency decide where they are going to put it.

Okay.

Markham: The same thing with all the narcs, either go-bag is locked.

I think the "or" idea.

The "or" idea works.

Surprenant: Lasix, 3 and 3, the reason being that we can only give up to 120 mg in the protocol. I don't know where this 4 came from originally.

Do we give _____?

Sometimes.

Surprenant: Technically, it's in the protocol. If we follow that one protocol _____

120 a day, if it's not working.

Surprenant: So that's the thought. I don't know where 4 is because we've never given that much in the field in that whole protocol so that's there. Haldol is a new one coming in. It would be 2 and 2.

Markham: Ipratropium, I think that should be 2 and 2, like we left the albuterol.

Surprenant: Lidocaine 10 mg, the max in that new protocol is 3 mg/kg so that would allow us to give 100 kg patient 3 doses or do we want more in case we have --

Markham: That would be 1 dose, 100 mg, 3 mg/kg would be 1 dose. I mean the total is 3 mg/kg so it is 1 mg per kg --

Markham: I was doing the math, I wasn't thinking about the protocol.

Surprenant: So if we were thinking, are you going to have patients who are going to be more than 100 kg, so we may want to keep it 4 and 4. With an a-fib protocol you are either going to do down the amiodarone tree or the lidocaine tree, but the total is 1 mg/kg up to 3 mg/kg. Dr. Lyng?

Lyng: _____

Surprenant: So can we anticipate that our patients will be over 100 kg, if we do, then we need to keep 4 and 4. I wanted to be nice.

I think 3 and 3 is enough.

3 and 3, okay.

3 and 3 should be plenty.

Surprenant: Lopressor, we're only able to give 1 dose so that is why that is at 1 and 1.

Witt: And it's falling out of favor, so I think the minimum 1 and 1, it's really falling out of favor.

Surprenant: Mag sulfate. I don't know if that is a highly used medication. The suggestion was to do it 1 and 1. Nitroglycerin spray which should have an asterisk as optional, so it will have 3 asterisks next to that. The thought is 1 spray bottle in the kit and the vehicle. Nitrous oxide will be –

Cooney: Is that an "or".

Surprenant: Yes, oh, good idea, tablet or spray.

Tablet is above it.

Price: They can carry both if they want.

The spray is optional, one or the other.

Okay. If you have the spray, you don't need the tablets, right?

Surprenant: Okay, let's just make it or. All right, nitrous oxide, that's optional, so with it converted in there that matches the main factor applies it. Zofran, we've already determined that when they came out. Currently we have 1 and 2. Then we get down, it's just -- that's good. Originally when we had saline kits we had the 10 cc vial and the 3 cc syringe with the needle, many agencies have gone to the prefilled syringes so the thought was if they want to keep ___ vial with the syringe with the needle or they just use the prefilled syringe.

Price: And you have the 3 ways listed here, but you took them off on the other side.

Surprenant: Yes, just cross them out. Okay.

The nitroglycerin can be tablets or spray?

That is what the suggestion was. I missed that.

Surprenant: Since we made a bunch of changes instead of – what I would like to do is approve the existing changes for transporting for this policy statement and what I will do is take the changes and mirror it to the ALS/first response because the first response was based on changes similar to the transporting, but we have made so many changes to this list, what I'll do for the next meeting in April mirror that and then we can get through the first response at that time.

Unk: Just a quick question. In the ALS/first response minimum requirements, you do not apply to ___ for that agency, is that correct?

They are two different.

Surprenant: We'll let you handle it, John.

Morrissey: The question was does the ALS/FR requirements are they required for all EASV's for the ___ and unless this REMAC has passed a requirement I don't believe it says that all of the vehicles have to be that level of care that they're authorized for, the answer is no.

Markham: Didn't we as a REMAC discuss this and say that, you know, a non-emergency -- like Dr. Fullagar's vehicle doesn't have to have the ALS -- Did we discuss that?

Morrissey: Or could have subsets. Let's say you only wanted to carry airway roll and saline blocks or IV fluids and that's it. He could do that. Again, you can approve subsets to those vehicles. But the short answer is no, it does not have to have the full ALS _____. You still have to have 18, 24 no matter

what you do to be licensed as an ALS/FR – correction, EASV is 820.6, but you have to conform to the policy statement because there are no regs for ALS/FR.

Olsson: Before we too many people _____, we're pushing our two hour limit on our mandated televising, etc., etc., so in the interest of common sense, I would like to take a vote on what we've just done and then next order of business I think would be to go home. So I need a motion.

Since it is part of a policy statement, just that portion of it.

Olsson: Move to approve.

Second.

Olsson: Favor?

(Ayes)

Opposed?

Olsson: Move to adjourn?

Okay, any new business?

Wallis: I do have something. Sorry, I don't want to open up a Pandora's box, but it is something that I did mention to Susie, and that is basically I would like to know if we could together some sort of task force or some sort of committee to look at the emergency departments in the area as far as receiving ambulances. And the basic problem is we may go to a given hospital and we may end up waiting for an extended period of time and lately it has been getting rather excessive and frustration on both the ERs, the staff perspective, and also from the EMS perspective to the point where I think the providers have been standing off or have had some sort of confrontation with ER staff, and I know that Susie, we had done a study back a year to a year and a half ago looking at this, but from a rural standpoint and I talked briefly to Troy that it even

affects the city aspect as well as the rural aspect when I'm talking a half hour to get my ambulance back up into my district, I'm not as fortunate to have multiple ambulances on at once. My next closest ambulance is at least 15 minutes away.

Unk: Does EPCR have the ability to track that? When document an EPCR your arrival time and your sign-off time?

Olsson: Getting back to Norm.

Wallis: I guess what I'm looking for, Dr. Olsson, is the fact that, I know that this has been a problem in the past, that I would like to see a collaborative effort between the hospitals and EMS to come to some sort of resolution in this. I don't feel -- I don't feel that people should be getting frustrated with each other. We understand that the hospitals are busy. I hope the hospitals understand that we are busy, but I think that there should be some sort of professional way that we can deal with this without having people get upset when we come into their facility.

Olsson: This is a state-wide problem. There are agencies in parts of the State that wait 3 hours to transfer patients over. It is unfortunately more of an ED issue than it is, we're affected by it, but we can't affect what they do. Certainly we can somehow communicate to the emergency departments that those ED directors that are in here, I don't want to speak for them, but they're apparently sensitive to the fact that they know it's an issue. The problem is that there are factors beyond their control and staff in the EDs need to be cognizant of turn-around times.

Morrissey: If I could, John Morrissey, State Health Department. There have been a couple of neat studies that have been recently circulated on this very issue, and if I may, Dr. Olsson, not -- I hear what you're saying, but with a little bit of disagreement. It's more than an ED problem. It's really an institutional problem of getting the patients out of the ED to the appropriate beds, it's

more so. John McCabe and I, as a matter of fact a couple of weeks ago, had a long chat about this very issue, and he is of the firm belief that that is the case, but doesn't feel a number of other folks in the community have figured that out as yet, and there has been that one study. Perhaps, Norm, what would make sense is ___ and the hospital executive council take that study along with John and a few others and re-look at this. There is actually a study out that talks about if you eliminate hospital diversion in your system you actually improve your patient flow. So again it's a local system issue, but I think you need REMAC, REMSCO reps work with the hospital executive council as far as to have a dialogue to start some education and look at some of this because it is a complicated issue and that may make a lot of sense.

Wallis: Well, the reason it came out once again was one of our providers went to University and he was told that University is no longer going to go on diversion. He ended up waiting for an hour and 15 minutes because University was not on diversion and we transported a patient there to find out that they were overwhelmed with patients.

Witt: This is Dr. Witt from St. Joseph's. I can reassure you that the ED medical directors meet quarterly. John McCabe and all of us who are medical directors of EDs and this is a top topic of discussion. We actually did decide to try a period of no diversion in Syracuse and it is my belief, my personal belief and professional belief that if we just said nobody is going on diversion, too bad, you get what you get, I think you would find that we don't need it. Okay, and I think that you would find that the volume would even out, but the problem is is even though I believe and John McCabe believes that, and you know, I think others believe it, there are people around us who don't believe that, and no one will unconditionally commit. If I was in control of my ED without anyone telling me what to do, I would say we're not going on diversion, I don't care, but you see -- and how are we addressing it. We currently keep a time study when an ambulance pulls in, they sign in, when they pull out, they sign

out. We're keeping our own time study. I know that other hospitals are doing the same thing. Number 2, we look at every single time in our ER every single week. We know how long it takes to get into a bed, how long it takes a doctor to see the patient, how long it takes to circulate through the ED, how long it takes to get them out. We have created a rapid admission unit upstairs. We have created -- but the reality of life is that the ED is the safety net for the whole damn collapsing system, and as rapidly we're making changes our volumes are growing and the social issues are growing so people stay longer, and so I really don't think that it's a problem that's not being addressed, it's being addressed regionally by the ED directors in this region who meet quarterly, and you know, we've even put together campaigns at St. Joe's about making EMS happy, you acknowledge them, you smile at them, you apologize, you know, I think everybody in the city and the region is taking that approach, but unfortunately there are going to be outlying times when the volume is overwhelming and some one is going to have to wait an hour and a half, but I think that is the exception not the rule, and I think that there are times when the charge nurse and EMS are going to have a little tiff or the doctors. That's the time when you pick up the phone and you call the ED Medical Director and say I would like this entire case reviewed because all of us have internal peer review processes, all of us address it with our nurses, our doctors, our PAs every day. It really is something that is a hot topic with all of us. It's right in the forefront, and you know, I don't know that forming another committee would help, although I wouldn't be opposed if that is what the group thought would help, I wouldn't be opposed to participating on it.

Markham: I just have one brief comment on that, and I agree with you, based on that, all 4 of the medical directors in Syracuse agree that we should have diversion and diversion is created as a solution to what we thought was an ED problem, well, with time we learned overcrowding in the emergency department it is not an ED problem it's a hospital problem, and we have created diversion as a

solution so we have affected EMS to try to solve a hospital problem which just doesn't work, and there has been a lot of studies, and I think all our feeling is that diversion should just go away because it's like a crutch that gives the hospital people an idea that that could be a solution to more of the emergency department problems, and we want to get away from that idea and part of that could be explaining to the EMS providers that, well, documented diversion doesn't work, we all know diversion doesn't work, and you know, I can't convince them in the emergency department that diversion doesn't work. I can show them the stats all day long.

Witt: No. And you can't convince --

Markham: And they will not believe that diversion doesn't work. It is a very emotional response that they have and that's why the hospital administrators will not agree to no diversion because their nursing directors are saying, oh, but we have to have diversion.

Witt: And because Syracuse is the city that created diversion. This is a whole cultural thing. Diversion started here. It's been here the longest, and the biggest problem I have coming from the outside in overall in my job is I am fighting a culture that is alien to everywhere I've ever been. You know, Knoxville, Tennessee just said we're not going to go on diversion. They've had no problems. You know, bigger cities, so we want that, and we want to change that culture, but you know, even the VP over the Emergency Department at St. Joe's, Mark _____, who is absolutely an angel and a champion, he was like yes, we want no diversion, yes, we want no diversion, and as soon as I said, we decided at the regional meeting we're doing no diversion and the clinical nurse manager and the nursing director went "WOOOOOO" he said we can't go on total no diversion.

It's all or none.

Witt: We wanted to go on no diversion.

Wallis: I understand, but I also understand the frustration from the EMS side, I understand your goals of wanting to be apologetic, we understand that you're busy, but quite often the people at the hospital don't necessarily present the way you would like them to, and I think that a lot of times they take it out on EMS like we're the enemies in this whole situation, and I think from the EMS standpoint people get tired of being disrespected or getting pounded on because we take patients to your facilities. I think you -- we are also your ambassadors so if somebody says which hospital would go to, the EMS people could say any one of the five hospitals do you wish to take them to. So we also market your service.

Witt: And we are all aware of that, and that's why in the exceptional case where you are poorly received you need to pick up the phone and call the physician medical director, and I can look at everyone in this room, there isn't any one of us that wouldn't review the case and talk to everyone involved.

Surprenant: My comment to the survey piece of that, what we discovered even though the diversion system, the policy statement of Central New York, we were not the authors of that policy statement. It was the Hospital Executive Council and the CEOs of the 5 Onondaga County hospitals, that was only intended for the Onondaga County, it was not intended for the whole region, Dr. ____ before us agreed to put that as a policy statement so I came in in the study, Tim had started it, and I continued it and finished it for us. We had over 4,000 people that submitted data, we found that it's great that we did the study, but we can't get rid of this policy. The Hospital Executive Council and the CEOs of the 5 hospitals are the ones that are going to have to get rid of it. But what happened is then all the other 4 counties hopped on and said we're going to go on diversion, and I find it hard that one hospital in one county can go on diversion.

Olsson: For the sake of formality, I want to end the formal meeting and tape and all that other stuff. We formally adjourn to our next meeting in April. Those that want to stay and discuss this, you're more than welcome to. Those that want to get home before the next lake effect snow storm which is in 8-1/2 minutes, and those of us that have other meetings to go to yet tonight --

Committee of the Central New York Emergency Medical Services Council, Inc.
January 8, 2009 Meeting Minutes

Name	Title	Present (X)	Status	Representation
<i>Members</i>				
Olsson, Dan	DO	X	Voting	Regional Medical Director
			Voting	Emergency Dept. Physician A Lee Memorial
DiRubbo, Mary	MD		Voting	Emergency Dept. Physician Auburn Memorial
Koch, Drew	MD		Voting	Emergency Dept. Physician Cayuga Medical Ctr.
Markham, Joseph	MD	X	Voting	Emergency Dept. Physician Community Gen Hospital
Wirtz, David	MD	X	Voting	Emergency Dept. Physician Cortland Memorial
Mills, James	MD		Voting	Emergency Dept. Physician Crouse Hospital
Iannolo, Patsy	MD PhD		Voting	Emergency Dept. Physician Oswego Hospital
Whitt, Therese	MD	X	Voting	Emergency Dept. Physician St. Joseph's Hospital
Fullagar, Chris	MD	X	Voting	Emergency Dept. Physician SUNY Upstate Med University Hospital
Kowalski, Michael	MD	X	Voting	Emergency Dept. Physician VA Medical Center, Syracuse
			Non-Voting	
Ambrose, Mark	RN		Voting	Emergency Dept. Nurse Cayuga
	RN,		Non-Voting	
Morrison, Jerome	EMT-P	X	Voting	Emergency Dept. Nurse Cortland
	RN		Non-Voting	Emergency Dept. Nurse Onondaga
			Non-Voting	
Greeney, Lori	RN		Voting	Emergency Dept. Nurse Oswego
			Non-Voting	
Novick, Melanie	RN		Voting	Emergency Dept. Nurse Tompkins
			Non-Voting	
Sowles, Donna	EMT-P		Voting	ALS Provider Cayuga
			Non-Voting	
Merrill, Peggy	EMT-P		Voting	ALS Provider Cortland
			Non-Voting	
Hogue, Troy	EMT-P	X	Voting	ALS Provider Onondaga
			Non-Voting	
Wallis, Norm	EMT-CC	X	Voting	ALS Provider Oswego
			Non-Voting	
Flynn, Susan	EMT-P	X	Voting	ALS Provider Tompkins
			Non-Voting	
Ware, Lucy	EMT-B		Voting	BLS Provider Cayuga
			Non-Voting	
Butler, David	EMT-B		Voting	BLS Provider Cortland
			Non-Voting	BLS Provider Onondaga
			Non-Voting	
Rathbun, Joseph	EMT-B		Voting	BLS Provider Oswego
			Non-Voting	
Flynn, Shawn	EMT-CC	X	Voting	BLS Provider Tompkins
			Non-Voting	
Kushyk, Donna	PharmD		Voting	Pharmacy
			Non-Voting	
Lago, Ron	PhD		Voting	Hospital Administration

DiGregorio, Anthony	EMT-P		Non- Voting	BLS Educator
			Non- Voting	ALS Educator
Fields, Maryann	RN		Non- Voting	Trauma Center
Loomis, Bob	EMT-B		Non- Voting	Dispatch Personnel
Darby, Warren	EMT-B	X	Non- Voting	REMSCo Chair
Mackey, Jennifer	MD		Non- Voting	Pediatric Emergency Medicine Physician
<u>Staff</u>				
Surprenant, Susie	NREMT- P	X	Non- Voting	CNYEMS Program Executive Director
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
<u>Guests</u>				
Sandra Hargrave				A. Lee Memorial Hospital
David Thompson				Rural Metro
Brian Calley				TLC EMS
John Morrissey				DOH
John Lyng				SUNY EMS
Derek Cooney				SUNY EMS
Tony Giachetti				