

Committee of the Central New York Emergency Medical Services Council, Inc.
October 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		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
Boyle, Michael	MD		Voting	Emergency Dept. Physician Oswego Hospital
Whitt, Therese	MD		Voting	Emergency Dept. Physician St. Joseph's Hospital
Fullagar, Chris	MD		Voting	Emergency Dept. Physician SUNY Upstate Med University Hospital
Kowalski, Michael	MD		Voting	Emergency Dept. Physician VA Medical Center, Syracuse
Ambrose, Mark	RN	X	Non-Voting	Emergency Dept. Nurse Cayuga
Morrison, Jerome	RN, EMT-P		Non-Voting	Emergency Dept. Nurse Cortland
	RN		Non-Voting	Emergency Dept. Nurse Onondaga
Ramsey, Dave	RN		Non-Voting	Emergency Dept. Nurse Oswego
Clawson, Melissa	RN		Non-Voting	Emergency Dept. Nurse Tompkins
Sowles, Donna	EMT-P		Non-Voting	ALS Provider Cayuga
Merrill, Peggy	EMT-P		Non-Voting	ALS Provider Cortland
Hogue, Troy	EMT-P	X	Non-Voting	ALS Provider Onondaga
Wallis, Norm	EMT-CC	X	Non-Voting	ALS Provider Oswego
Flynn, Susan	EMT-P	X	Non-Voting	ALS Provider Tompkins
Ware, Lucy	EMT-B		Non-Voting	BLS Provider Cayuga
Butler, David	EMT-B		Non-Voting	BLS Provider Cortland
			Non-Voting	BLS Provider Onondaga
Rathbun, Joseph	EMT-B		Non-Voting	BLS Provider Oswego
Flynn, Shawn	EMT-CC	X	Non-Voting	BLS Provider Tompkins
Kushyk, Donna	PharmD		Non-Voting	Pharmacy
Lago, Ron	PhD		Non-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>				
Ruth Boshart		X		
John Morrissey		X		NYS DOH
David Thompson		X		
Penny Shutts		X		
Naveen Seth		X		
Brian Calley		X		

Olsson: Okay, I'm going to go ahead and call to order the October 8th, 2009 meeting of the Central New York REMAC. Once again, they ask that you use the microphones, speak clearly and plainly and state your name before speaking. The minutes from July 16th were sent electronically for your perusal. I will make one note that we did start late due to an hour and 15 some minutes of the Executive Council meeting. The SEMAC/SEMSCo report from September 2nd. Hydrocortisone was added to the State formulary for specific use in pediatric acute adrenal insufficiency cases. This stems from the parents foundation dealing with kids with congenital adrenal hypoplasia. Within our region, I believe there are 2 kids, both in Cayuga County, both of whom have the medication at home. They have the dosages. They have the syringes. The concern is that the parents may be too squeamish to give it prior to transport. This is within the scope of practice for paramedics and if any patient in that regard is encountered, then the medical control just needs to be notified prior to the administration and then these kids will automatically be transported. Ketamine was added

to – or is in the process of being added to the State formulary. The Bureau of Narcotics Enforcement is working on forms, etc. Yet another version of the State ALS protocols or guidelines was distributed. This is actually the very nice product what was done by Sharon Chinema in Rochester was to take all of the protocols from all 18 regions and did them in a common format. It has been distributed and we'll just see where that goes. Albany region submitted a vast hypothermia protocol for return of spontaneous circulation after cardiac arrest. It was passed, however, it was deemed to be a research protocol, and they're now going to have to go back to their IRV. This is something that the other hospitals in the State intend to do then that is something that can be looked at as well. There was a question that came up on patient destination for trauma arrests, and it came from another region where in a traumatic arrest do you go to the closest hospital or do you go to a trauma center if it's less than say 10 minutes away. And what the SEMSCo in their wisdom said, it sounds like a regional and local issue so deal with it at the regional level. That is something that what I think we'll do is send it out

in a newsletter format so that we can at least think about it, and decide what we want to do anything differently than what we're doing now. I don't know how much of an issue it is in Central New York. In one case that we're looking at from the Watertown area where it's clearly an issue. There was one case in Auburn that the crew very appropriately basically disregarded what the physician said and went to the Auburn Hospital anyways which was the right thing to do. Anyway. Next, blood transport, the blood transport people at the State are still working on the forms and procedures and certification. The bottom line is that EMS does not transport blood or blood products without a licensed medical provider, i.e., a nurse. There is an H1N1 disaster committee that has said things along the lines that if you're sick don't go to the emergency department and don't call EMS. They're recommending that an alternative phone number be set up at the 911 center that can handle those calls. The influenza immunizations, if you are an Article XXVIII hospital employee or you are an EMS service own and operated by an Article XXVIII hospital then it is a condition of employment you can be mandated to receive the vaccine. That is not true for all other EMS providers. EMS is a primary candidate and they are at the top of the list to receive the vaccine. John.

One addition in Albany is that Jim Sutter told me about yesterday, if you're an ambulance service that has a contract with a hospital for doing interfacility work then those contract employees have to be vaccinated, but if you don't have a contract and you're just going in and out, taking patients in, you don't need the immunizations.

If you are a student within the hospital, then you have to comply with all of the regulations. There was a question about EMTs giving the vaccine. If you watch any of the news programs, they're all saying that there is going to be a shortage of individuals to administer. It's within the scope of practice as far as the mechanics of giving a shot,

however, vaccines are considered prophylactic treatment. They are not treatment after the fact. So therefore it doesn't fit that particular scope of practice so somebody's looking at it. The Fire Department of New York presented a study of prehospital organ retrieval. It's not really what it sounds. They are going to be doing a study on the procedure whereby individuals that have an active DNR that feel, that are in arrest or have an organ donor card and do not survive prehospital resuscitation there will be a separate vehicle that will come out and take the body to an accepted hospital to do the organ retrieval as opposed to just leaving it. For those that don't know, Ed Wronski announced his retirement effective December 2009, and the educational committee there were not enough applicants for EMS Dispatcher of the Year so the award will either not be given or they won't continue submission up until something comes up. That is it in essence for the SEMAC and SEMSCo. _____ I'll let Susie do the Executive or CQI report.

Surprenant: The CQI report, it was given in Executive session. Program Agency report, we all know the protocols rolled out on 09/01/2009, so those have been in place. Under old business, there is the thing on protocol roll-out on Haldol and Dr. Olsson will just bring a highlight of. So far we haven't heard of any issues with any protocols or any concerns. We had a regional CQI meeting before this. We asked the hospital representatives that were present if they had any issues or questions. They did not indicate any. One of the things that the hospitals did get was a very large god awful colored binders so they can be easily identified that went to each hospital with 8-1/2 x 11 version of the protocols so that they can be put by the radios in each of the hospitals. We also provided smaller protocol books for physicians and nursing staff. We told the hospitals that if they wished to have additional copies we can prove them. We have also provided to all of the agencies for their vehicles as well as their providers and even ILS and ALS classes that are coming up so that everybody is well aware of the

protocols. There is a downloadable PDF version on the web site as well for people to access. We still have people that have not completed the update. They were warned several times that if by 09/01 they did not complete it they would get a suspension letter, and we put those out. There are some people that took an update that haven't taken the test so we've been tracking those down. The nice thing about this protocol update since the other two were done on line this will allow us clean up some _____. We've noticed that some of the volunteers that have either dropped a card or haven't recerted either have not told their agency and they're still on the agency rolls or they've just dropped EMS. So the nice thing is that the agencies that aren't the busier services or the ones, you know, just have a few ILS or ALS providers could clean up the ranks so they will know exactly who is currently practicing in this region and who is not. Some have given valid reasons. They were out of town, _____, some were on medical leave so we've got a large spread sheet in our data base to keep track of everybody and agencies, notify each agency so they know where their providers are as well. We're just trying to keep track of some of the ones that do want to continue practicing to get the update, and we've heard a lot of good comments about the material and the consistency of the presentation.

Olsson: Thank you. Questions for Susie? We'll bounce back up to Air Medical Services, they met today. Warren?

Darby: Air Medical Services met at noon today. We had 3 of our major providers there, Mercy Flight Central, New York State Police and Air One.

(_____)

Darby: That's right Guthrie was there too, four of them, I stand corrected. We had review of -- the medical director reviewed 131 PCRs from March to July of this year and it breaks down to Air One 7 calls and 2 of those were no transports. New

York State Police had 48 calls, 25 of which were no transports. Mercy Flight Central had 76 calls and no notation of no transport. There were some substantive issues with regards to some medications and some PCR report in writing and some PCRs were returned to the agencies to be corrected. We talked under old business about the Federal lawsuit that's still hanging with the Onondaga County Sheriff's Office and the Clearinghouse is still on the docket waiting for the judge locally here in the Northern District to get it on the calendar and then hopefully _____ Western Federal Court did and dismiss the suit, but that is not on a calendar to our knowledge yet. I've checked with the attorneys, and we're just waiting. . Under new business, we talked about the 2010 funding battle that is going on for Air One right now. In fact, I believe the REMAC is going to the public hearing at the OnCenter within the next 15 minutes, and we will probably be there for most of the night because this is the one night that we can have public input into the budget and Air One is just a piece of that. There is lot _____ I suspect. There was discussion around a letter that we received from Mercy Flight Central, in fact we received it at the meeting and basically what it said was that Mercy Flight Central was not going to be participating in a clearinghouse effective 10/15, and they put messages out to all of the regions' dispatch centers urging them to call them directly through the toll free number, 800 number, and if they couldn't handle the call they would find the next available appropriate air medical service for that call. There was discussion about this same issue having come up back, years back, and this committee had to deal with it and Dr. Yastremski was the medical director back then and it was decided that one, if they didn't call in and give a status to a clearinghouse, if they could still be on the grid, they would be at the bottom of that grid. The Air Medical Services called in and said they were in service would be the first closest available—they would be the first to get your call and if none of those were available, then Mercy Flight would be called to see if they were in

service, and that's the way it was dealt with back then. It kept them on the grid and kept them in play, but they would need to call us and give status, if they were in service to move up that grid, and also a letter from the medical director went out to all of the county dispatch centers indicating the way to get the air medical service to receive would be through the clearinghouse _____ medical direction for our regional medical director. We have signed agreements from each of the regions that indicated that they will abide by that so that was what was done then. We discussed it further here. It was pointed out that there were some appeals to that and at that same time the appeals _____ ruled that REMACs can mandate EMS protocols within their region and so that was the outcome, and they _____ 15th of October, Mercy Air Flight Central was at the meeting and _____ information back to their powers to be. It was also pointed out that Tompkins County in our Central New York Region has not been planned _____ clearinghouse and it was brought to the attention of the Air Medical Committee and we are looking into if that's true and why. _____ There was some discussion by Mr. Morrissey that the AMS committee _____ looking at the issue of coordinating air medical services possibly on a state-wide level in New York State, and there was some discussion by the providers that probably one of the safest ways would be an ADL system _____ for the safety of not having 2 in the immediate area _____ closest available identify it as such and it was indicated that there are 47 aircraft in New York State now so that isn't that big a project _____, we may be hearing from those hearings and recommendations in the near future _____ clearinghouse on a state-wide basis rather than just on a regional one. There was some discussion brought up about the University Hospital Trauma Center's new helipad up on roof #12 or 13 floor, but it's up there. This was to open in mid November and right now they're talking about closing the current _____. There was a motion carried unanimously by the committee to send a letter from the AMS

committee to the powers at University Hospital to request that the old pad stay useable or can be turned on if necessary _____ as opposed to going out to Hancock and each of the services also indicated that _____. We may have some more news with regards to that in the future. _____.

Olsson: Thanks, Warren.

Morrissey: John Morrissey, if I may one thing. The meeting that Warren is referring to, the meeting done by the Federal Aviation folks and preliminary recommendations have come out that they are recommending a centralized clearinghouse, our anticipation is which has been discussed _____ state-wide, we will be looking at those recommendations as a state-wide tag and looking at that we've had this conversation with _____ clearinghouse, but I also need to counter that with budget timeframe right now and so forth _____. Thank you.

Darby: One more _____ point. We did have one audit on the operational side of the house, it was discussed in the letter from Mercy Flight to myself directly complaining of a call back on the 22nd of August just over the line at Cayuga County, on a motorcycle accident, and it turned out that Air One was in the air which put them closest available when the call went over the fire radio that Mercy Flight Central was being dispatched out of the clearinghouse. After auditing the call and all the players, we found that in fact Air One had gone in service on a patrol flight at 1723 hours that evening with a full crew, a flight paramedic as the protocol requires and we let the clearinghouse and the 911 center know that we were staffed for EMS. We were doing some Homeland Security airborne checks that we do on a regular basis and then we assisted the State Police on a vehicle pursuit so we were up there for a while and then at 1745 a call came – this call came in on this crash, this motorcycle, we were in western Onondaga, heard it come over the fire radio and immediately we told the clearinghouse

that we were in service and therefore we would be first up. We could see the crash site from where we were when it was called into the clearinghouse and said that they were trying to get a hold of us, apparently dispatchers had changed at the clearinghouse and they had not passed the information on that we were in the air, they immediately canceled Mercy Flight, they were about 3 minutes into the call, and we were on the ground, we were packaging the patient, a 13 minute transport to Upstate, and we were back in service so it was the appropriate way to go, but it was felt that we were call jumping until we were able to _____. _____ letter went back to Mercy Flight and everybody else that they had cc'd _____.

Olsson: Thanks, Warren.

Thompson: Just two comments, this is Dave Thompson, one is Mercy Flight is a CAMES accredited organization and if I am correct CAMES has a standard that requires the air medical services that are accredited to participate with the local EMS system so that there may be an issue there I'm not 100% sure. I don't have those standards in front of me. The other is providing the vehicle locator, almost all aircraft today have satellite tracking, and it's really a matter of bringing that information whenever it's going through the internet, you can track almost every flight today _____ these helicopters don't have a flight plan necessarily _____ actually ___ brand new _____.

Darby: _____ that issue, a group east of them _____ and they are tracking all of the air medic -- _____ see where everybody is and in some areas that's important _____. That's certainly a safety factor _____.

Olsson: Okay, thanks, any questions about air medical? Suspension, revocations. Edward Ashley, West Stanford, New York, for a year's suspension which was stayed, 3 month actual

suspension, EMT-Paramedic, and 3 years probation and a civil penalty of \$2,000. Jeffrey Mondo, Lackawanna, New York, suspended August through November for failure to comply with a previous stipulation order violation of part 800.15 and 16. Samuel Stetter, suspension effective 09/21 for failure to comply with a previous stipulation of order, there does not appear to be an end date on that one, suspended. Susie?

Surprenant: Protocol for Haldol, what occurred was we had a couple of agencies call where they had seen in the Haldol packaging, it's IM only so Dr. Olsson got some information _____ also provided some literature to each of the agencies and basically left it in the hands of the agency medical director if they felt they did not use Haldol as IV. We looked into it, you know, this was approved by the REMAC here, it was approved SEMAC it is IV or IM, and it's also used in several other regions in the same way that the SEMAC did not feel that that was an issue or change that when it was presented to them, we're not the only region having that so we left it up to the agency medical director if they felt that they were uncomfortable with that being given IV just change it to IM so that is the only thing that we know of right now _____. We're not the only region that _____. The intubation form has been out for a month. I'm going to give a reminder to folks that any intubation and/or use of secondary airway device _____ to fill those out and send them in and one of the things that we do have to do from that is give SEMAC after a year is the information on that from a QI perspective so that does have to be reported to the State as part of the advisory and the other thing that we will be doing is developing some educational pieces, especially the capnography piece _____.

Olsson: Many of you may be aware of the fact that over the last, well, since 2005 or so, we, at least from the physician's perspective we have tried to formulate some form of physician

response for prehospital. We are finally getting close to that in the form of the Upstate EASV. Anybody that has come in through the back or the south entrance, there is a large white Ford or something or other there with a lot of signs on it. We're hoping to get that on the road the first of November. Dr. Naveen Seth in the back is our EMS fellow who will be one of, if not, the primary person behind the wheel, and what we're planning is an informational outreach program over the next several weeks to couple of months to try and get everybody informed as to the what, where, why, when, etc., so more to come on that.

Surprenant: Blood glucometry. We've gotten applications or pre-packets from NOVA and NAVAC for their BLS providers to do blood glucometry, so what was decided when this policy statement came into place is each time we meet I would give you an update _____ so we've added 2 more to the mix and then Hannibal Fire Department sent us a notification ___ copy of that, one of their ALS FRs, they've downgraded to a BLS FR, so they are still an ALS FR agency, they have just looked at one of the vehicles that was not getting as much use and decided to down grade that to a BLS FR. Going to the controlled substance box, one of the things that has been discussed several times here, it usually centers around a CQI issue, is the way our controlled substances, most of our agencies are carrying little red boxes, we've had those for quite some time. The only disadvantage is that you can't see what's in there, if something gets broken, you can't look at the concentration like you can other medications unless you do it at ___ time and have some empties there. One of the things about 2 years ago Faxton-St. Luke's in the Midstate Region were looking at – said where can you get the little red boxes, I said, please don't get the little red boxes, this is why, and I said it would be best if we discussed here something that is clear. So what they've come up with is a box, and I'll pass this around, and it's a see-through box, and the thing that they do is have pin in it with a tag on it, the only thing with the pin issue is they tend

to lose those quite a bit and it's \$5 a pin. So looking at this with Dr. Olsson, I said, it would work better – replace the pin with a cable with a lock, _____ just a tag on there, right now our boxes are tagged as well as having a key. I would prefer something with a lock. This box may not fit for everybody so I'm checking with the company to see if they have a couple of varieties of the same, but a different size. Fayetteville, this would be a little bit too big for their agency, but looking at the red box, this is a little bit wider and a little bit shorter than our current red box that most agencies have so I'll pass this around. The thought is, do we want this as an option. If you want, I could pursue ___ will this work for a couple of agencies. Some of the agencies that have had controlled substance issues have said that we will spend the money to get new boxes. The original box – that box cost \$50 ___ cost about \$35. The agency said it would be worth not having the headaches, the issues that they have. Some of them come prepackaged from like St. Joseph's is a good example, and you have to fit _____ so that box would not work for everybody, we would have to modify it so it's either stay with the red boxes for some agencies or provide that as an option if they're willing to spend the money and switch over. We have talked about it, that's just one option of having something that's a clear box.

Morrissey: Susie, _____ we've approved this out in Utica _____ one thing with most people's systems that are in place, you're going to have to do a seal through the bar and then you're going to put a padlock on top of that, because people who are using the red Snap-On tool boxes, one of the two keyed systems to make that work. So the cable thing as much as I like it, I've got to have a seal and a lock so just think that through. In terms of agencies adding this, they are solid plastic, you can get something called a plastic router, you can buy which you can take and cut and modify these boxes pretty easily internally and it doesn't fog the plastic I am told. The Utica folks have been creative in that regard so again whatever works for people. The red boxes are acceptable. This is

acceptable. We've had some people make boxes out of sheet metal with hinges and so forth, again whatever works for the service _____. _____ save some money for the agencies.

Surprenant: The key is as long as it is sealed as well as locked, correct?

Morrissey: Correct. Has to have the tamper seal from the pharmacy and then the physical padlock so that will become one of the key ingredients and probably 95% of the services who are currently doing it that _____ a couple of places ____, but that's rare.

Olsson: Can the seal be inside of the clasp? _____ and that would have a lock ____ agencies get through their stuff.

Morrissey: It certainly could. The tamper bag numbering is what we're looking for because we're using the seals as a form of key card ability. Because the trade off is you have to have some form of key card ability so the electronic clock will remember the seals. We would have to work through it, but it's a potential possibility, yes.

Olsson: So for those agencies or for any agency, one of the big issues that we've seen on their CQIs is the fact that whether it's light of day or 3:00 in the morning, providers misread what's on the tool boxes, and, the only time that they see it is when they use it so this is something that is really important. Under new business C, REMAC committee restructure. One of the items that has been under discussion actually that has occurred throughout all the regions in New York State is the corporation agency medical directors to sit on REMAC. The original article R lists that there is a representative, a physician representative from the hospital, this is basically what makes up the voting _____ that's the format that we've always used here. One of the issues that came up in the last protocol roll-out was that even though we have reasonably good representation, we could have better physician representation by having

agency medical directors sit and make decisions. To me this makes portion makes a lot of sense. This would incorporate _____ council meeting for example. Dr. Iannolo who is potentially no longer at Oswego, he would be able to sit on the REMAC as TLC and NAVAC so what I would like to engender is number 1, a brief discussion and see if we can come to some consensus about accepting REMAC-accepted – agency medical directors to sit on the REMAC that would require a passage through the REMSCO, it would have to go to the REMSCO as a second – a seconded motion. The second thing that would need to happen is that there would probably have to be a redefinition of a majority vote and quorum because we're now changing the structure and again talking to other regions, several regions define a quorum as the physicians that are present, no matter what the number is and then a majority is more than 51%. Simple and straight forward. So I would like to hear your thoughts on the addition of agency medical directors to sit on the REMAC physician voting platform. Don't all speak at once. Jerry.

Morrison: Jerry Morrison. I think one of the advantages, too, is that if we have the hospital representation, now we would have more involvement and better carrying down of information from the REMAC for recent protocol changes, actually even better information coming back out from the agencies themselves so I think there is a definite benefit for them being _____.

Thompson: This is Dave Thompson _____, it is very frustrating to be – working with one of the busier services in the region and that have really no say in protocols so _____ voting membership.

Olsson: Penny?

Shutts: Penny Shutts, would there be a limit on the number of agency medical directors, would that include _____ REMAC per county?

Olsson: We didn't discuss that earlier today actually, and my initial thought is no because I don't know what mechanism we would exclude someone. I don't believe, also, that we're going to be overrun with agency medical directors clogging up the system. I think that our preference off the top of my head would be to throw it open to everybody and if it got to be too cumbersome then figure out how to taper it down, and if you look at the physicians that currently sit on the REMAC that's 80% of the agencies are already represented.

Surprenant: 80% of the REMAC physicians represent agencies and one of the other things we thought of was there's physicians that have multiple agencies so even though we have 60 ALS agencies and about 170 BLS and ALS we don't have 170 physicians representing them. Dr. Koch, you represent quite a few in Tompkins County, and you know, Dr. Iannolo is going to say that he's got two different agencies, actually if you consider Brewerton and Auburn, it's really 4 agencies. Dr. DiRubbo, the same way, multiple agencies so originally we were talking about the physicians that have played an active role in the REMAC, even though they were not REMAC physicians, and decided that the number was not a concern unless it became overwhelming.

Olsson: Troy.

Hogue: Troy Hogue, just a couple of comments. You mentioned the REMSCo needing to vote on it, just to get people up to speed, REMSCo has already looked at this and has asked the REMAC to do this so the timing is great. There was actually a vote on it at a REMSCo meeting, two meetings ago I believe, that they would like the REMAC to do this so and left it in your hands so that message didn't ___ that's what they're looking for anyways so it's a positive thing. The number – I would agree, I don't think that there should be any limit. I would love to have a problem with needing to find a bigger room. And

just a question, the agency medical directors at this point are they credentialed through the REMAC or is there any type of approval processes, because if not, I would encourage us to do that.

Olsson: Yes, they are. So does that mean that it's coming in as a seconded motion from the REMSCo to the REMAC.

Hogue: The REMSCo dealt with this and asked that the REMAC look at this, voted on it and said that they wanted the REMAC to restructure to have a REMAC that was reflective of EMS agencies. I don't know if it requires any more

Morrissey: Yes, it would I think. John Morrissey, State Health, I believe what we're talking about here is modification of the by-laws of the Regional Council which defines the complete –

Hogue: No.

Morrissey: Because it doesn't do that.

Hogue: The by-laws of the Council do not address the makeup of the REMAC.

Morrissey: So then all you're doing is changing what is traditional policy here.

Hogue: Correct.

Morrissey: And that sounds like you needed a seconded motion back from the policy from this organization. But this is technically a subcommittee of the REMAC – excuse me, of the REMSCo, and I believe your quorum requirements for the Open Meeting Law of New York State which this falls under, I believe, your constitution and by-laws govern that. Okay, and I'd be happy to call Albany to get the right answer in terms of that, but my point is the only reason I mention that, in Binghamton about 5 years ago they restructured their REMAC and added a

number of physicians who did some things and based on the quorum crisis occasionally they found themselves short of making a quorum based on the Open Meeting Law to conduct business. Now, it's interesting, I've never heard the solution that Dan just suggested and it sounds good to me that by by-law or policy whichever it needs to be, Troy, is to define the quorum as the number of physicians in the room which is cool with me, but it's a creative way to solve that, okay, that problem, and that helps you, too, I think, let's be real, there have been times where I've had to come to this REMAC and ask the guys, sometimes when we were in the early days, post 9/11 where we were dealing with bioterrorism things and saying, look, I may need the physicians to get together quick on a telephone conference call to implement some fast protocols, _____, as we approach the season of swine flu we may be facing some crises here in a few months that we haven't anticipated, we may need the docs to get together to say, we authorize everybody to give flu vaccine, or do something, you know _____ so having small quorums that open quorum thing, I kind of like that _____ so that's my only concern here, you just need to make sure that it works cross back to the full Regional Council.

Surprenant: So there's an operational guideline that actually lists the makeup of the current REMAC so we talked to Warren on _____, was it Wednesday – Tuesday, and we said this is what's going on, which had started before with the Council, actually Dr. Olsson has been talking about it for a while about changing the makeup, especially since some of the physicians that were REMAC physicians have now switched hospitals and lost their role that have been valued members of this committee for quite some time and how do we retain that back so that we discussed that if it's approved here it change the operational guideline, put the quorum piece in _____ and then it would come to the Council just as a vote which could happen in November.

Hogue: Right, this could come as a seconded motion from the subcommittee to be put before the full Council because this is a subcommittee of the Regional Council.

Olsson: That's correct. So it looks like we're actually only looking for 3 motions. One is to incorporate agency medical directors into the physician voting component of the REMAC, number 2 is to redefine a quorum as the number of physicians physically present any one meeting and number 3, a majority vote will be 51% or more of the quorum.

Morrissey: If I may, physically or virtually, because if you do an electronic meeting where you have to do a teleconference or something, also we do that, just defending that.

Olsson: So we just need somebody to make that amendment because I can't.

Unkn: I make a motion to do all three things.

Olsson: Do I have a second?

I'll second it.

Olsson: Any further discussion? Of all the physicians present, all in favor say aye.

(Ayes)

Olsson: Opposed. Abstain. Passed unanimously. Thank you. All right, we'll get that out to the REMSCo for the next meeting. PCRs.

Surprenant: Dr. Wirtz had asked to add PCRs to the agenda. I will let him have the floor and then I have what was discussed at regional QI as well.

Wirtz: I'm sure if this isn't any new problem, this has been an ongoing complaint almost _____. So this has been an ongoing issue of getting timely PCRs back to providers _____, action on _____ or if it's more of a State issue _____.

Surprenant: So seeing that that was on the agenda and it's been on the agenda for Regional QI in the past, since that meeting was before that, we discussed it with the ED managers that were present from the hospitals, they're seeing it as an issue as well. Since John was there representing the State what was decided, and we wanted to bring it to this group to see ____ before that, was we sent out a reminder from myself, Dr. Olsson and John Morrissey, the Article XXX requirement as well as the policy statement requirement of completing the PCR in a timely manner. Do a friendly reminder that way. In the meantime the hospitals and the ones that were present, we were going to provide this with, is that in the next few months if they can identify an agency, a specific agency that's having an issue, then Mr. Morrissey will ____ that specific agency.

Morrissey: We will jointly do another letter or what seems appropriate at the time because we do look at this. We look at, when we're doing the annual service inspections, we look at you're doing in quality assurance ____ and if the REMAC or, you know, the Program Agency is identifying the issues that are not participating in CQI or not providing PCRs on a chronic ongoing basis we need to fix that. I did want to make it clear here, you know, I don't know, Rural Metro may be in St. Joe's ER 500 times a month, I don't know, maybe a thousand, and we're talking about 1 PCR, 2 PCRs out of a thousand, I'm not, you know, that's a pretty good percentage to hit in terms, you know, of all things considered. I think we're talking about much more significant, longer than that. I just don't want to chase small stuff, but people who are chronically violating this sort of thing we want to work toward that.

Surprenant: So does the plan that the Regional CQI came up with sound appropriate.

Olsson: Yes.

Morrissey: It will be somebody from our office. I may ask Paul Eaton to sign off or the hospital program director or, you know, but you will get a signature from our office, _____ central office, we will get somebody to co-sign.

Surprenant: And what we can do for January's meeting is put that as old business and then give you a progress report ____ and I think, too, as more agencies go electronic and have access, then it would be an appropriate thing. I know Tompkins County, they're ready to – the thing to access the charts, the hospital can, but whether a hospital decides to do that or not it is up to them, but they do have hospital agreements with EMS charts where the hospital ____ PCR, log on just like I can or Dr. Olsson and print that chart. So some regions do it that way, but if we look at the policy statement it still says that you have to leave a copy of the patient care record, it doesn't specify paper or electronic, but you've got to leave a copy there. So I think the hospitals' concerns that we were hearing in the region, it wasn't a 2 hour delay or a 24 hour delay, we're talking days or weeks and sometimes didn't get a whole stack of PCRs and then they have to go to medical records, they've ____ concerns about the hospitals that were there about the issues. Triage Tuesday, Ann ____ from University Hospital, there's a document that says Emergency Preparedness Regional Resource Center, and they were talking about coming up in February, March and April and they're actually called Triage Tuesdays. One of the things when 76 Smart triage tags came out, EMS got trained extensively on the use of these tags, but with the finding that that training did not always come into the hospitals and the hospitals are used to the old tags, they're not familiar with the new tags, so one of the initiatives they came up with is that hospitals and agencies in this region that we should participate is that they would have three dates where there would be practice use of the tags that the patient would be tagged in the field, they would track the outcome _____ take the priority tag and then the evaluator look at it, see how well they're using the

Smart tags. So the hospitals that were represented by the ED directors were for that, already had Crouse and St. Joe's are willing to do that so any hospital within this region is able to do this and any agency. So I told anybody just to email me and the more the merrier, but they want to try this coming up the first of the year so I have included their program, there's a timeline here as well as the evaluation sheet.

Olsson: Any other -- I guess I didn't ask if there was any other old business. Old business, new business or --

Koch: Yes, I have some new business. My name is Drew Koch, I'm from Cayuga Medical Center. I would like to bring up a proposal to have Steve Knapp read, also, to see if we can run a pilot program in Tompkins County.

Surprenant: What we uncovered when we tried to do the airway study was, when you say study, even though we termed it differently, it was viewed by the State that we needed the IRE locally as _____, but realizing that the CPAP was going to come up again and missed being voted on in this region by -- I'd have to go back to the minutes by 1 or 2 votes, I do still have the protocols where, and I've talked to Dr. Olsson about this before we started that, is if we could revisit that particular protocol where CPAP was included which is acute respiratory. The protocol has already been developed. It was to notify the protocol committee, it was brought to this committee as well as the other protocols, but it was voted down by one or two votes and realizing that it was such a close vote and that it would be resurfacing which is a good thing so my suggestion was in January when we come back, I would give the same protocols again and I know we try to avoid stickers, but I think with this thing that it would be worth the effort to go through, we would still have to go through the protocol approval process, but if it was voted on in January, a 30 day comment review, it would come back to this committee in April and then go to

SEMAC for a vote, it would involve putting one sticker on the respiratory with the CPAP included in there and the protocol was written in a way that I know it will pass SEMAC because it mirrors other regions in that section so that it would pass at that level and not get delayed.

Olsson: It would also not have to be a pilot because it is done in other regions and it is an accepted modality in most places and the way I think we could handle it is, as Susie said, a mandate would go to the SEMAC as an agency option which I have little reluctance to do because I think -- I hate having however many agencies, half of them do it, half of them don't, this and that. The other side of it is though that it is potentially an expensive investment and I would be reluctant to mandate it throughout the region, but if agencies felt that this was something that they wanted to invest in and that is important from their medical director, I think it's a reasonable next step. The other thing I have a quandary or a dilemma with is going to the SEMAC every 6 months or every 12 months with another protocol. The whole process is very omnibus and recently with the CPAP, it's a very straight forward thing and it should engender very little discussion so it's a very straight forward so we will bring to the next meeting as we did with the other protocol, we will put it up on the view screen, look at it, we can vote it and then it will go out for the 30 day and then it will come back and we'll send it to the SEMAC and then it should go through.

Surprenant: Because you're not the only county, we've had several requests since then, where this stands and the nice thing with that is I can mail or email those protocols, the versions out ahead of time so if we need to make any changes to it we can so that we can accomplish that, you know, present it and vote on it in January and start the process rolling.

Koch: Our hospital, this is Drew Koch, received accreditation by the ___ Center from Columbus, Ohio, there are 500 hospitals in the country, we're

trying to get accreditation in CHF and by not
having CPAP _____ accreditation,

Olsson: Any other business of any thing? In that case, thanks to everyone for hanging in there with us. This meeting lasted a little longer than typically. I know we had some times when we had nothing to do but chat so once again thank you for that. We'll entertain a motion to adjourn, and we'll reconvene January 14th, 2010 at 1700. Have a good safe holiday.