

Committee of the Central New York Emergency Medical Services Council, Inc.
April 9, 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	X	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		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		Voting	Emergency Dept. Physician St. Joseph's Hospital
				Emergency Dept. Physician SUNY Upstate Med University Hospital
Fullagar, Chris	MD		Voting	
Kowalski, Michael	MD	X	Voting	Emergency Dept. Physician VA Medical Center, Syracuse
Ambrose, Mark	RN		Non-Voting	Emergency Dept. Nurse Cayuga
Morrison, Jerome	RN, EMT-P	X	Non-Voting	Emergency Dept. Nurse Cortland
	RN		Non-Voting	Emergency Dept. Nurse Onondaga
Greeney, Lori	RN		Non-Voting	Emergency Dept. Nurse Oswego
Novick, Melanie	RN		Non-Voting	Emergency Dept. Nurse Tompkins
Sowles, Donna	EMT-P		Non-Voting	ALS Provider Cayuga
Merrill, Peggy	EMT-P		Non-Voting	AIS Provider Cortland
Hogue, Troy	EMT-P		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	X	Non-Voting	Trauma Center
Loomis, Bob	EMT-B		Non-Voting	Dispatch Personnel
Darby, Warren	EMT-B	X	Non-Voting	REMSSCo Chair
Mackey, Jennifer	MD		Non-Voting	Pediatric Emergency Medicine Physician
<i>Staff</i>				
Surprenant, Susie	NREMT-P	X	Non-Voting	CNYEMS Program Executive Director
Eckstadt, Tamara		X	Non-Voting	CNYEMS Program Administrative Assistant
Jones, Jeff	EMT-P	X	Non-Voting	CNYEMS Clinical Consultant
Price, Colleen	EMT-P	X	Non-Voting	CNYEMS Clinical Consultant
<i>Guests</i>				
David Ramsay	Oswego Hospital			
Penny Shutts				
John Morrissey	NYS DOH			
Brian Calley	TLC			
David Thompson, MD				

Dr. Olsson: Speak in the microphone, say your name. The microphone is going to pick up everything that is transcribed so – we are limited to 2 hours by design, hopefully it won't take that long. And without any further a due. Strike up the band. Also, make sure your microphones are on by the way. Okay, I'd like to go ahead and start the April 9th meeting of the Central New York REMAC. I will call the meeting to order. The minutes from January 8th have been sent out electronically. Hopefully everyone had a chance to review that and I will entertain a motion, for comments, concerns, acceptance, etc. Blank stares.

Move to accept.

Do we have a second for acceptance?

Second.

Olsson: All in favor?

(Ayes)

Opposed? Carried.

Olsson: At this time we will deviate from the agenda for just a moment. The Undersheriff has to trek north, and therefore, if we could do the air medical services report.

Darby: Warren Darby. Air Medical Services Committee today at noon. We had our Mercy Flight Central, New York State Police, and the Onondaga County Sheriff's Air Medical System present. We talked about the statistics coming from our clearinghouse of our calls for the first three months of the year. We still have an issue with regards to getting all the times into the clearinghouse

computer and that was specifically a Mercy Flight Central issue. Mercy Flight Central said that they will next time before the next Air Medical Services meeting do a summary of all of their flights and give it to the clearinghouse so that they can fill in the times. Dr. Olsson did medical review and they gave direction to the agencies – feedback with respect to the charts, and we had a discussion with the New York State Thruway over the repair, actually the replacement of the Thruway between exits 39 and 40 which just started this week. It is a three year project, and they came over to explain how they're going to be diverting the traffic from one direction over into the other side while they tear up and literally replace from scratch that stretch of the Thruway over a three year period. The concern was that they had talked to the first responders, fire and EMS and police, State Police being primary on the Thruway, but had forgotten to talk to the Air Medical people so they came to the meeting, explained the process over the next three years, had maps with them and are going up tonight in Air One with cameras to look for possible, what we used call LZs, L spots, for issues that might occur on the Thruway. They were telling us that they have two or three disabled vehicles about every commute hour in that stretch and two accidents every other day so over a three year stretch that is an issue. They have said that they will shut the Thruway down if we need to bring a medevac in onto the Thruway itself, but they're looking for spots off of the construction area where they can set down and then fly in. One suggestion was that they may end up having to bring by ambulance to either end, Weedsport in or to the Onondaga County side and then medevac from there. So

we were looking at that tonight, and with a small subcommittee coming back to the Thruway with their suggestions. We had the State Medical talk about their new tower and the new heli-pad that's up on top. The FAA has received the paperwork to look at that new heli-pad. There is a plan that when in fact that goes into operation that the old heli-pad would not be the backup, but rather we go out to the airport, set down there and come in by ambulance. The Air Medical Committee is going to be writing a letter to the hospital and asking them to reconsider that plan because of the delay and we do have a facility that could be used as a backup. In July there was going to be a get together, a day set aside where we're going to ask EMS to come on in and see the new pad because there is a visualization on this new site, I don't see a whole lot of the pad when you're up there standing by for the helicopter to come in. We want all the folks to get a chance to get up and take a look at that so that may be happening in July. We're going to facilitate that as a community _____. The next meeting is going to be in October, October 8th at noon. That's all I have.

Olsson: Okay, Thanks, Warren. Any questions for Warren? In my usual spirit of efficiency, I can't find my SEMAC report. It's in cyber space somewhere, and when I figure out which computer it's on I will put it out as an electronic mail to every body. Suffice it to say, I don't think that there was anything overtly earth shattering that came out of it. In lieu of that, we will move on to CQI report.

Surprenant: Susie Surprenant, with the CQI report. We have had all reviews in all counties except Cayuga since

January. Some significant, we've had two issues with separate providers for pacing, and also two issues where cardioversion was suppose to have been delivered, but defibrillation was actually done. These four incidents actually happened in a period of less than a month. We were surprised – was this just an anomaly because in the past three years we've not had an issue of cardioversion and pacing or do we need to look at a little bit more education for CVM so we're going to be looking at that to see if we can provide some more education on CVM, then correct some of that from happening. The nice thing is that we are also working to see if some of the cases that were unusual if we could be recreate in the sim lab for educational purposes. So we're working with EMSTAT to see if that is available as well. We also had an issue with intubation for a cardiac arrest that we are dealing with. There were two medication errors. There have been several that have been reported to the State because of 800 violations. One that got directly reported to the State and prevented the provider from credentialing in this region until that case was cleared up, and we also have two paramedics that are suspended because of cases that have been reported to the State for ____ violations. We've gotten these from different avenues. We've had hospitals these as well as agencies reporting those. So we're very pleased that agencies are doing practical QI and looking at this and if there is an issue reporting it for us to look it. We've had a couple of issues that have been dealt with internally by the agency medical directors. We've had their use as well. Right now, the cases, basically the ones that are outstanding, we're just waiting for the remediation to be done _____, so that's a

good thing. So right into the Agency Report, and currently right now we are going through some updates on our web site which was created when Tim Perkins was the Executive Director. Since then it has grown, we've basically got basically 2700 providers in our region and almost 200 agencies so the web site and the functionality of that at least from the administrative side we're making some changes to allow for more agencies as well as more provider information. Some of the spreadsheets that we've kept information on is actually incorporated into the web site. So behind the scenes we see it as actually a very large data base that we're using to export to Access, Excel, and be able to use that, and we're actually to grow that. It's going to have six regions' worth of information and the reason for that is that all providers that practice in more than one region to just register and, Norm, if you don't mind, I'll use you as an example, he practices in Midstate as well, because he won't have to do CMEs and credential in one region and we will have collaborative agreements between those six to make it easier for agencies to have providers in more than one region and help with staffing. So we're working to upgrade that. With those regions, we will also have the same – CMEs will be the same as well as credentialing. So we're trying to get collaborative agreements with those to make that a little bit easier and with that we will have information and it will also link to the FuNCMeS web site so providers that can register with your appropriate region will be able to get into that site, that has been upgraded as well to allow us to put more educational presentations on that so we're gearing more towards education and when we're not web casting, the server space is actually

servicing FuNCMeS sites so we're actually getting a good education piece on there when there is no web casting up there. We're working on the protocols. Where we stand on that, we've looked at the third draft from the printers, and the reason that we're going through so many drafts is, I don't want to inherit the stickers again. I inherited that from Mr. Perkins and I don't want a sticker any more so we're looking at them very carefully because there is literally a couple of hundred changes that gone into this book, and then we're going to be printing 2500 protocol books. So it's a considerable investment monetarily so we want to make sure that those are accurate. The nice thing as that has been happening Dr. Olsson has developed a criteria and the curriculum for the new skills that are going to be rolled out. So our goal is to get these books produced so we can start educating people in May and June or a mid-July rollout. So this will be a very extensive rollout because of the new skills as well as so many protocol changes as well as the introduction of certain new protocols, new medications that are being instituted.

Olsson: Any questions for Susie? Okay. News that you can use from the State, we're required to release by rule or law. Suspended 1 year effective 02/09/09, probation for 2 years, civil penalty \$2,000, Stephanie Crespo, _____ violations of Part 800 16c and _____, from Pelham Manor, 1 year suspension, suspension was stayed, 3 year probation, civil penalty \$3,000 in violation of Part 800. The suspensions are not necessarily unique to our region. We don't see them very often. We're starting to see a creeping trend that the individuals who are getting close to Part 800 violations if

not there already. This is getting to be worse, and we're looking at this in the CQI process _____ so a word to the wise. Okay. Old Business, I want to talk about the general equipment list.

Surprenant: There were hand-outs, there was actually 2 separate hand-outs, one for the ALS transporting agencies and one hand-out for the ALS first response units. The transporting units we actually went through and voted on the January 8th meeting so I just have that so we can reference some of the changes because of those changes were carried forward to the ALS FR. So on this, the ALS FR, basically what's highlighted is new, the changes that are being implemented. Prior to this, we had cardiac monitor for ILS, CC and P. ILS is only able to use an AED so that line was added in so AED is listed for ILS and then monitor for CC and P. This mirrors what we did for transporting. Wave form capnography has been added in there and then we had pulse ox only for paramedics, we've added that in for CC and ILS as well. We've changed the name of the Broselow tape to the pediatric measuring device so we're not using any trade names as SEMAC has requested. Jeff brought up that we didn't have a protocol in there so the protocol is part of the ___ equipment list. I thought that was a very good idea. We've included that for the vehicle and we've also included that for transporting medical vehicle and the portable equipment. Then we came down to the water soluble jelly. On the transporting unit, we decided to decrease it from 6 to 4 so that mirrors that change. We've also had the combi-tube where it is replacing the LMA so those quantities for the small and large are the same for transporting. One of the things that we did get rid of

was back stock for the transporting agencies as well, so I assumed that, that's we're going to do for first response agencies as well. Our theory was to leave it up to the agency to make sure that they had enough in back stock to make sure that their ambulance is not ___ equipment so that they can determine that based on the _____. Laryngoscope blades, what we discussed in January was originally we had one set on the ambulance and the first response units. The discussion was to have two complete sets for transporting and I wanted to know if that is what you wanted as well as the first response unit.

Olsson: There is one nod no and bewilderment.

Morrissey: John Morrissey, I'm the one that originally identified this as an issue out of some case reviews that we had done that you may want to consider having a set in the carry along bag obviously as we before we traditionally had and then another set on the shelf because occasionally the bags get left on the scene and then there no way to do airway management during the transport. The ALS piece, I don't think that you would want 2 sets. _____ they're not transporting in that vehicle. Again, that was the original genesis of the suggestion.

Surprenant: Any other comments on that? Dr. Markham?

Markham: This is Dr. Markham. It is my understanding of our conversation, too, that ambulance should have extra equipment for initial response and would just have one set of equipment. The only question that I have here is, maybe you can refresh my memory, why do we

have four 3-0 endotracheal tubes in both and one or two of everything else.

(_____)

Surprenant: So the discussion for the laryngoscope blades was one set on first response and two sets per ambulance, is that correct? So what we'll do is we will switch those back to one per the handle and all the way down on the blades. The rest – the adult/pediatric Magill forceps is the same. The EDD and esophageal detector, even though we have capnography, the SEMAC advisory is that we have this as the secondary backup device to that so we have one of each for those. In the transporting we had originally two nebs and we increased that to three. I didn't know if we wanted to keep that the same or leave it at two. Jerry?

Morrison: Jerry Morrison. _____

Surprenant: Yes. We discussed that as well. So we do want to keep the nebulizers at two or bring them up to three to match transport? There are agencies here with ALS FRs, it's your time to speak.

Markham: Dr. Markham. My feeling is that they ought to match. They're pretty small, don't take up a lot of space.

Fricano: We have some people in Cayuga County that are pretty good on stepping on them.

Surprenant: We will keep nebs at three. One of the things that has not made our list was gum bougie. It was not a required piece of equipment, but after seeing some of the CQI cases that we've had that, it would have been a useful

piece of equipment to use or could remember to use. Our recommendation from the Executive CQI was to see if this group would add it as a required piece of equipment for both transporting and FR.

Susie?

Calley: Brian Calley, TLC. As far as the gum bougies go, I've used them and there have been a number of tubes that I would have never gotten in the field without it. I couldn't support that enough. I think it's crazy not to have them.

Surprenant: I think the cost is --

Calley: Six bucks a piece.

Surprenant: Yes, I mean they're inexpensive compared to some of the _____. So --

If you were having trouble, Brian, you should have called me.

We wanted to get it done today.

Surprenant: For ILS, CC and P, one on there and the transporting agency would it be one in the portable and -- two in the portable and one in the --

One in the portable and two regular.

So ALS first response is one?

Surprenant: One and then transporting -- so gum bougie for transporting, you're saying one in the portable and two in the ambulance?

Olsson: Now's the time if you're nodding no.

(_____)

We used to carry the one in the portable and one in the ambulance. So if you have them, why would you need another second bougie on the ambulance?

I was thinking the same thing. We're talking about minimal equipment

_____.

(_____)

Surprenant: Okay, so one portable, one ambulance. The theory being that if you want more than that, go right ahead. Moving onto the second page of ALS FR. We had large bore saline lock kit, we had 6 originally in transport vehicle, and we reduced that number to 5. So that's _____. For the IO needle, previously we only had peds listed with new protocol. The adult is also on there, and that's for the CC and P so that line has been added. Neosporin, we reduced from 12 to 6 for transporters and that is the same. Now to the med list. When I was talking to Dr. Olsson, I noticed that we've got several meds that basically ILS and BLS can do that we've never included on this and that is activated charcoal, albuterol, aspirin, oral glucose, Epi-Pen, you have to go through additional paperwork for that so that's why that's not on there. So my thought is if this is a minimum equipment list and BLS can do these skills as well as ILS then we need to add this to the ILS for minimum equipment so it's out there, it's in the BLS protocols and didn't know if you wanted to add that to this minimum equipment list. So activated charcoal for ILS has been marked on there. Then we came to adenosine, we had 5, added 6 and then we've marked

ILS for albuterol and aspirin.

Amiodarone was originally at 2, but with the new v-fib protocol we're going to need a little bit -- a couple more to make it through that protocol when using amiodarone all the way through, I guess is the technical answer. Fentanyl is the same as with transporting and that matches the policy statement from the State on that. Oral glucose was added because it's never been in the minimum equipment list. The Haldol, that matches the quantity carried in the transporting as well as Lopressor. The next changes come in the very bottom. Here we had nitro spray, nitrous oxide and those quantities match what we put for transporting, and the other 3 meds that we added were part of the RSI protocol. I didn't know what doses we wanted for those. Rocuronium the dose on RSI protocol is actually 60 mg, succinylcholine is 150 mg, and the 2 doses of _____ MAC come up to 10. I didn't know if 2-2-2 were sufficient for that. That will get you through that protocol if your agency is approved for RSI. Zofran, we had a brief _____ at REMAC when that protocol is introduced to actually put 3 in there so that's just been added to that list.

So if your agency is not going to RSI, then you don't have to carry it?

Surprenant: Correct.

So that needs to be stipulated.

(_____)

Surprenant: That's why on the very bottom I put agency must be approved by the Central New York Region to perform RSI.

Olsson: But does that mean they still have to carry it?

Surprenant: No, that's why we've got the star so --

Olsson: If that's understood, that's fine.

Morrissey: John Morrissey, New York Department of Health. A friendly thought. Could we -- many regions in the state are now mandating that if you become an ALS agency you must carry narcotics. I realize that is not the stance of this REMAC and that's okay. Reading this, it would just say, oh, that asterisk reminds us we have to be licensed to carry controlled substances because it doesn't show this as the option which it has been. So could I just ask for some verbiage or something so when this gets reviewed and so forth that mandate is not there.

Olsson: To carry narcotics?

Morrissey: You got it. In other words, you may want to put another similar, another symbol, just say oh, by the way, this is a regional optional equipment, because that's truly what it is here. There is not a mandate to carry narcotics.

Olsson: Controlled substances.

Morrissey: Correct.

Surprenant: That's a regional option.

Morrissey: Right, but -- it doesn't carry that same thing in this reference section so you can't really determine that if you didn't know about this conversation, the history of this REMAC.

Surprenant: So anything that is indicated as a controlled substance also indicate on that line that it was also regional --

Morrissey: It's a regional option, but must be licensed with the Department of Health to carry it.

Surprenant: What I can do is that change that line that's right there.

Morrissey: And could we maybe even go one step further and just put that the single patient doses are what is listed under the portable kit, that's it, so when the pharmacists call me and say, show me now that's single patient dosage to repack these new red boxes I could reference this list and say that REMAC voted on it and that's what they said, here it is, so that way it cuts some phone calls down. If you follow my thought process there.

DiRubbo: Mary DiRubbo from Auburn Memorial Hospital. It might be easier just as you went equipment and supplies, then you went down to medications that have been the same highlighted and put down regional optional equipment and under that anything that carries those three stars would be there and then again you can put RSI agency equipment with approval and put the four stars on that so it would be very easy to read when somebody looks through.

Surprenant: I like that suggestion. Based on Dr. DiRubbo's suggestion, we will put separate headings for those starred items so they can clearly see that, what's optional, what's part of the controlled substance based on that. Dr. Thompson.

Thompson: Going back to the quantities, I'm not familiar with the cost of these drugs. Are they expensive or no?

Olsson: Depends on the drug, some of them can be very expensive.

Thompson: For the RSI procedure at least, very costly drugs or not?

Olsson: The rocuronium might be a little, the other ones should be dirt cheap, but I can't tell you what they are off hand.

Thompson: In any event that certainly is an issue for EMS providers, but if we're going to do this, I'd like to see us have at least 2 complete sets of these drugs, one in the ambulance, one in the bags for obvious reasons. I've had some calls, if you're doing RSI on somebody you've probably got your hands full, there's a lot of hands in the mix and so there's always a chance of somebody dropping, or breaking or contaminating so I think if an agency is going to do RSI they ought to have the capacity to have 2 complete sets of the medications in case they run into a problem or have they more than one patient.

Olsson: Again, this is minimum.

Right.

Olsson: So if an agency wants to carry more, along as we are not dealing with controlled substances it should not be an issue because these are not controlled.

Thompson: Right, just a thought.

Olsson: Rather than mandate it, they can carry however much more they want.

Morrissey: John Morrissey from the State Health Department. Just a friendly reminder that we've had issues, all agencies with this, with etomidate. And it has been going to these RSI drugs that are not controlled, the benzo products, please be sensitive to the security, the ongoing accountability of these drugs in your operation.

Surprenant: Any other comments on the ALS FR?

Olsson: One thing that we're – I'm looking at real quickly, the use of trade names for Haldol and Lopressor. Given the latest or ongoing – not wanting to step on any manufacturers' toes, it's probably reasonable to eliminate Haldol and just leaving haloperidol and the trade name for Lopressor – the generic for Lopressor.

Zofran is a trade name.

Olsson: Zofran will be need to be changed as well.

(_____)

(____) is Cetacaine is a trade name?

Olsson: I think it is, but I don't know what else it can go by.

Morrissey: It starts with a "B" but I can't remember _____

Posterior pharyngeal anesthetic spray?

(_____)

Cetacaine, it's a long chemical name.

Olsson: We'll try not to get too carried away. We'll try and go through and eradicate that without getting too crazy. We'll let the powers to be complain ____.

(_____)

Surprenant: Or put generic equivalent _____.

Olsson: I have no problem with that.

That would be better for recommendation.

Yes, okay.

Surprenant: Dr. DiRubbo.

DiRubbo: Dr. DiRubbo, Auburn Memorial Hospital. Just a quick point. If we do change these to the generic names, it may be worth sending some type of educational out to the providers, as the people in this room say, what's with aspirin, what's the generic names, we may want to get those out because when the list goes out there with all the generics, they're going to be what are all these new drugs so we may need to do an educational component in the spring or the summer to just let the people know what the generic names mean.

Surprenant: That is a good point. With all those suggestions, any others before we approve this list?

Olsson: All in favor of the changes? Opposed? Carried. Next. Let's go on with old business. Stroke centers. There has been a flurry of emails, letters, etc., especially centering on the stroke and health concept. At least as of the last State EMS meeting there are none in this region. So there is one hospital to the

southeast of us who has given TPA for strokes and have been reasonably successful, they have a neurologist, and they have video and what not. But they have not gone through whatever steps so as far as I know and as far as we have heard from the State, there has been no change in the stroke centers in the last six months. Lee Memorial – Dr. DiRubbo?

DiRubbo: Dr. DiRubbo, Auburn Memorial Hospital. The stroke centers in the region are SUNY and Crouse Hospital, correct?

Olsson: And Cayuga Medical Center.

DiRubbo: And Cayuga Medical Center, okay. And are they considered the spoke hospitals or telemedicine hospitals that are hooked up with stroke centers, currently is Cortland Hospital?

Olsson: There are no spoke hospitals in our region –

DiRubbo: What needs to be done for it to be a spoke hospital?

Olsson: The State – the hospital would have to go through the approval process and have a site visit and be so proclaimed by the powers in Albany.

DiRubbo: As a spoke center or as a stroke center?

Olsson: As a spoke stroke center.

Dr. Olsson?

Yes.

Unk: Now, what you're referring to, does that permit the stroke spoke

hospitals who receive ambulance patients or is that still only the designated stroke centers?

Olsson: Only the designated stroke centers. If the patient shows up on demand or whatever, and the as yet unnamed stroke spoke center wants to give TPA, that's up to them. But that facility cannot hold themselves out as a spoke stroke center.

Morrissey: John Morrissey from the New York State Department of Health. This was reviewed ostensibly with Albany and Dr. Young who is one of the site visitors indicated at this point that absolutely a spoke stroke center are not acceptable destinations for ambulance patients that meet stroke criteria

_____.

Olsson: Okay. Anything else? Lee Memorial.

Surprenant: Lee Memorial, they're closing on 04/26. We were contacted by the Department of Health that Lee Memorial sooner can say EMS needed to stop transporting 911 patients as of April 4th. So that went out to all the agencies in Oswego, also some in Cayuga as well as Onondaga that would be transporting as well as Jefferson County and Oneida, to surrounding regions so everybody was notified to stop transporting 911 patients between now and 4/26, they are getting any patients transferred out of that hospital and will close as of 4/26 and then that's it, and they will open up as an Urgent Care after that. So we're working on a regular basis, a weekly basis, conference calls with the agency chief in Oswego County as well as Oswego Hospital to see what the impact is going to be on that county as well as Onondaga

County, and the hospital executive council is also honoring the patients that are coming to this county from those agencies to see if there is any impact on the local hospitals. That's being reviewed.

Olsson: Okay. Thank you. Any other old business? New Business?

Surprenant: McFee Ambulance which is a paramedic transporting service in Oswego County has one ambulance that's actually a BLS vehicle, so anticipating that they are going to be doing some longer transports and they would like to get one more ambulance to ALS so I've planned an inspection for next week to inspect that to make sure it has minimum equipment and that will give them 3 so they will have all paramedic equipped ambulances. Aurelius Fire Department was previously an ILS FR, it's going to BLS FR. Brewerton Ambulance as of 02/01 contracted with TLC EMS to provide staffing for that agency. New Hope Fire Department in Cayuga is going from ILS to BLS FR. I have been contacted by Palermo Fire Department which is in Oswego County, which is critical care, and they're probably going to be doing paramedic level service so we're going to be looking into that and in the process of sending out some proposal letters so that can be presented here officially. There was another Oswego FR that was looking at going into paramedic service as well. So we're losing two ILS, but we're probably gaining 2 paramedic FRs at least in Oswego County and it kind of evens out. And the reason for the change to upgrade is with capnography, we said that we've got to do is carry a few more meds and we can be paramedic level.

Olsson: Okay. I'd like to at this point spend a little bit of time on looking at a policy statement, specifically 9704, and I don't know how many people either remember or are aware that that, some time around 2004 or 2005 there was a group of physicians, Chris Fullagar, Walter Kantor, Joe, I think you were part of that as well, and myself, and one of the things that we started doing is to look at how we could more formalize physicians' response and the use of physicians in the prehospital setting, specifically the REMAC physicians and agency physicians, and this is part of the outline that we came up with and one of the things that we looked at was we wanted to make sure that they had the right people with the right skills and the right background, you might as well scroll down a little bit. And then we talked about what was some of the basic requirements, insurance, base station, and there had to be some kind of approval process or acceptance by the regional medical director. And we went through what are some of the just generically some of the courses and background that we felt that physician responders should have as minimum. And you can see that – that's listed there, okay. And actually this was from the June 14th meeting that we did in '05. Okay. And again we tried to look at and delineate to some degree of specificity, but also with some degree of generality and what it boiled down to was that we wanted the physicians to be able to do a couple of things. One is quality assurance, anybody that sat in this room long enough and has gone to the CQI meetings realize that sometimes the only time that you find out that something happened is "x" number weeks later by looking at a blank PCR. And that's very

difficult to judge what happened, and it is certainly easier if there is somebody there and in real time can say, wait a minute, let's see what you're doing here. The second thing is that in rare occasion when having a physician there will give you direct medical control, you're going to save potentially a fair amount of time, simply because all you have to do is turn and say, hey, can I do this? So those were the two big pieces that we looked at back in '05. This has resurged or come back up again, do you want to bring up that other document? Within the Upstate Emergency Medicine Resident Training Program, there has been an EMS and disaster fellowship so this is a physician who has completed three years of emergency medicine residency and is now doing a year of specialized training in EMS. And one of the things that – the intent of that program is just to get that person out in the field along with the experienced physicians. It does quite nicely dovetail into what we have been looking at some four years ago, five years ago. One of the aspects of that is what we had for a policy statement regarding physician oversight and that's what's up on the screen. And what this policy, the gist of the policy, what it does, it describes what the REMAC does, what the on-line medical control authority does and how the ALS and BLS agencies function under the auspices of the REMAC, and so one of the things that would be beneficial is if we adapted or updated rather the policy statement to include something along the lines of what would be needed for physician response. We already have four, five of us, six that are already doing it, at least in Onondaga County, and so having perhaps a more formalized policy statement which could be or would be beneficial. This is the

first rough draft and so what I would like to do is open up for a short comment. I didn't bring my body armor so be careful, thank you. Any ways, comments?

DiRubbo: Dr. DiRubbo, Auburn Memorial Hospital. This is away from what you just pointed to, but on part of that policy statement, it says each ALS and BLS agency within the Central New York Region will identify an agency medical director. Previously it was BLS transporting agency or –

Olsson: It was BLS defibrillator, BLS-D. It was CFR-Ds, actually CFRD and EMT-D. And that was because in order to have a defibrillator you had to have a physician – an agency medical director. The reason that that got changed which is somewhat independent of everything I just actually was talking about, we have had at least one, if not more instances, where BLS providers have not followed BLS protocol, and the argument from some of the providers was that the REMAC only oversees ALS and therefore has no authority over BLS, and unless my understanding from Mr. Ronski is wrong we do have oversight over BLS providers and so even though the REMAC does not authorize BLS protocols we still are responsible for their actions and so the – that would be the oversight for the BLS providers.

DiRubbo: Would they then, BLS nontransporting agencies still be able to identify the REMAC – the regional director as the medical director. My BLS non-transporting agencies do not have individual medical directors, they've always pointed to you as their medical director, Dr. Olsson, would that be able to continue?

Olsson: Yes, that will not change. This was – this was in here as long as we were looking at the policy statement, my feeling was that it was best to try and bring it up to as close as we could to 2009 so we didn't have to relink at it.

Morrisey: John Morrissey, New York State Department of Health. One of the things that – when you get that reaction of the BLS providers, there was a time where the position of the REMSCO, the SEMAC was that BLS was totally hands-off and that has shifted as we know with some of the legal challenges, the Suffolk County case and so forth. As perhaps as one of the build-outs of this upcoming update is that we may want to remind everybody that that is a change, and services to know it. I think it is not that they don't mind it, they're just going off outdated information, and I don't know that we have ever formally told them that.

Olsson: Colleen?

Price: Colleen Price, CNY EMS Clinical. The only caveat that I would like to add _____ unless you sign a paper _____.

Olsson: Right, so with that signed --

Price: So even with BLS agencies that are also PAD sites, yes, for the BLS protocols _____, can just assume regional direction _____

Olsson: Despite the fact that some others do.

Morrissey: John Morrissey, just wearing my street provider paramedic hat for 30 seconds if I may. I think this is a great

protocol. Could I offer _____ responder ____ identify them on radio of the vehicle, but if somebody is off duty in a restaurant and shows up and I don't happen to know them as a medical control physician, we might want to think about some way to identify them. Because at one point we had – the policy was, we put that physician on with your on-line physician and they decide who will run it, and I just thought that this was good, but you might want to have credentialing or some way of identifying out to providers so that does not add an extra element of –

Olsson: Consternation.

Morrissey: Yes, thank you.

Should we have _____

Olsson: There are two things. One is that we have discussed at least briefly badges, the other change is that if and when we got to a point where this was more widespread than just Manlius, WAVES, whatever, we would want a web site, there would be a page for physician responders that they could access, there would certainly be emails going out and on those rare occasions where they are unknown, then that could be a problem. It is something I don't know if it would be in the body of the policy statement, that's my only problem.

Morrissey: A simple suggestion of what some systems have elected to do, ____ individual physician a series number that they identify themselves with that number and you hear that series number you know, okay, they're from the system.

Fricano: Lon Fricano from Cayuga County. There are a couple of issues that I would like to raise that may be not exactly what we started this discussion on. One of the problems from the field perspective is inconsistency from ____ medical control. Even in my career which spans more time than I wish it did, when you call one hospital you get one kind of reception, you call another hospital you get another kind of reception, you have doctors who come on and don't know the difference between a paramedic and a critical care technician, not familiar with all the drugs and procedures that we carry or where, the difference in perspectives that a paramedic or a critical care technician would have. It's not unique to Central New York. In New York City, I was a New York City paramedic by training, I spent a number of years working there, at one time in New York City, to obtain medical control you would call the receiving hospital similar to what we do in Central New York. As a result, there were a lot of inconsistencies in delivery of medical control, it posed a problem for field providers. What they finally did, was they centralized medical control for the entire city so they had specially trained physicians who actually sat at a central communications point to provide medical control for the whole system and that gave them a much better perspective in terms of making sure that things were being done the right way, identifying problems, keeping quality where it is, especially in our system where we are very fortunate that most, at the paramedic level, at least we're working on standing orders, we don't have a lot of on-line medical control. We more in a reporting function for the most part when we're on the way to the hospital. But I'm wondering if we

shouldn't be thinking about that because obviously there's big difference between a doctor that works in a trauma center at a resource facility that's specially trained in emergency medicine and a medical director for an agency who may be a pediatrician or a family practitioner who is lending his license or her license to the agency to allow them to function, but really is not, you know, mainstreamed in thinking of emergency medical services so I just wanted to raise that as kind of a global issue and wonder if there might be some discussions, maybe not now, but as we go forward and advance the system with more drugs and procedures and being able to really, you know, fine tune our system, whether we should not consider something like that.

(_____)

Olsson: Yes, and your point is very well taken. And that's true in our region and it's true elsewhere. There are regions that do centralized medical control and that is also the debate at the SEMAC as to who does it. Is it a paramedic that does it, as it is in some places, why would a paramedic give orders to another paramedic, that's another issue. Is it physicians? So that is occurring elsewhere.

Fricano: On that point, doctor. One of the reasons in the systems, New York City had a paramedic sitting next to a physician, but that was not to give orders, it was be the – to let the doc know, hey, our guys can't do that or, you know, they can do that, that's obviously had a different focus, different training, different expertise, so that that was more of an adjunct for the physician to make sure that everything was –

Olsson: There are regions to this day who are using paramedics to give orders, but that's beyond our discussion.

Fricano: Right.

Olsson: One of the things that we identified with our initial discussion had to do with what were the backgrounds, and the primary backgrounds were either emergency medicine or critical care, and then we would add whatever – what's that driving thing?

EVOC?

EVOC.

Olsson: Stuff like that, EVOC, SIBO. And definitely recognize that. We also clearly recognize the fact that – at University Hospital, you get 10 different orders for the same thing from 10 different physicians. We have attempted to standardize it with a base station course. Sometimes that it works, sometimes it doesn't. It's – I don't know how to make it really mandatory because there's no teeth. It's up to the medical director of that ED to make sure that everybody goes through it. Our intent and our background so far is that we are limiting the members of this group right now to emergency medicine/critical care. I don't think if we had a pediatrician that wanted to do field response, then we – not in the policy statement per se, certainly in this document _____ the fact that there has to be a certain amount of background training and then there's an approval process. Bear in mind there is also growing pains and that's also where – someone like a pediatrician who would desire to do this and jump through all the hoops, then it's going to be a work in

progress. What I wanted to do tonight was to at least bring out the concept of the policy statement and find out what were the major concerns of the statement and the concept. Dr. DiRubbo.

DiRubbo: Turning back to the policy statement, looking at the second paragraph that's highlighted. It says, the actions of these physicians will be in accordance with current accepted medical practice, and do you want to put Central New York EMS protocols, then the period. Just it brings the position, if there is an argument, well, I'm a licensed physician and I want to do this, it brings it back to the previous paragraph saying that you need the approval. So instead of it saying just the actions in accordance with current accepted medical practice, go and Central New York EMS protocols. It gets the argument between a physician and a paramedic on scene, the physician says he can do it, the paramedic not, the paramedic can refer to that we need to follow our protocols which would be the above paragraph.

(_____)

Olsson: Do you just want to type in –

Markham: I'm not sure the concern is already covered _____.

Olsson: Dr. Markham.

Markham: I think that that's covered, essentially the next sentence, the very next sentence said at no time should there be a request made that the prehospital provider exceed their capabilities. The physician doesn't follow the protocols, the paramedics do, is essentially what that says.

DiRubbo: Right, but if you're a paramedic, and you're uncomfortable with what a physician is doing, you've got –

Markham: If you're a licensed physician in New York State, and this is an approved EMS physician by REMAC responding to the scene, you don't have to have ___ to do medical care.

Markham: However, but the paramedic _____, that is what that second sentence is saying. We can't ask them to exceed their skill level.

Calley: Dr. Markham.

Calley: In addition to that, Brian Calley from TLC, in addition to that, if that physician comes on the scene, and ___ something that is beyond the protocols then that physician better step up and ride in with that paramedic. You get further down here and there is the statement that, about their – additionally each physician will preempt the the implementation of the physician on scene policy. So in effect it says, Joe comes up and says to me, crack the chest, I'm not comfortable with that, he does it, says okay you can take it in, that's not going to be a problem because Joe is going to be tied up in the rig and going. I can certainly see where this would go.

I can, too.

And whether or not _____.

Kowalski: Dr. Kowalski. That's the reason why every single one of these physicians that are not going to be an at-large member, are going to be approved

by the REMAC and the system, it's not going to be every willy-nilly six-gunner out there. There's going to be very few people who are known in the system by the system.

Markham: And just to say, we understand that, too, but it probably wouldn't be a bad idea to just throw in our line of policy saying that, you know, a physician who is ordering or practicing beyond the scope of the paramedics, they must assume care of that patient and take him to the hospital or all the way to the hospital. That should cover that.

I mean that's something _____

(_____)

Morrissey: John Morrissey, New York State Department of Health. I just want to advise this REMAC that at my bequest on the 7th of May, I think it is, just off the top of my head, I have asked the program agency staff to meet with me in Utica. We are reviewing the policy related to narcotics controlled on inter-facility transfers. There has recently been identified in a neighboring region, on issues that medical direction during their facility transports when you send other staff. Who is in charge and how that's going to work out. And one of the things that I'm hoping – it's one of the things that we've discussed the concept in creating this transfer form, sending the physician who authorized the use of protocol for that inter-facility and narcotics use _____, but if you send nursing or respiratory therapy staff or whatever now, who is in charge of the patient, that needs to be delineated out. I would offer that this policy or perhaps a separate policy may want to set the rules

of that _____. I think that with now narcotics ___ narcotics, the accountability of _____ very important. Correction that date, it's May 5th.

Olsson: So what I would like to do if there is no more major comments at this point, did everyone get a copy? Okay. Digest this and for the next couple of months and –

Fricano: One other question that occurred to me as you were talking. Lon Fricano. So let's take the view _____ where a physician does not have to go into the hospital, they've provided some on-scene face-to-face medical direction, right now, if I call medical control, I talk to Dr. DiRubbio at Auburn Memorial Hospital and I get a narcotics order, or I have a situation that requires a protocol deviation, and she tells me that's okay we can go ahead and do that, there's a record of that, it's on tape. Again looking from the provider perspective, you guys can do what you want, you're licensed physicians, but we are not. So I visualize a situation where a medical control physician on scene says something to me, I say I want to give this guy 5 of morphine q5 and he nods okay, and so I've got my order, now I go to the hospital, I deliver the patient, somewhere along the line somebody goes why did you give this guy 20 mg of morphine, well, the doc on the scene told me and the doc says, no, no, no, no I didn't tell you 5, I thought you just wanted 5, so there's room for confrontation, discrepancy so I'm just wondering what your thoughts are about handling that so that we don't –

Markham: What I do, I take the PCR and I write my order and sign it.

Surprenant: Actually there was a call that actually ___ where I flew in, had the patient and we did use control substances, basically went to University Hospital and Dr. Markham got on telemetry and talked to Dr. _____, this is what I've already ordered so I came in, the conversation already happened so they already knew that this physician already let us do these procedures and it was already on the taped line and that worked perfect. So we didn't have PCR's _____

Fricano: Electronic PCR's _____. We just need to address the issue of how we get a document that an order was properly given and properly followed.

Markham: Especially with narcotics, I agree with you that order needs to be documented.

With a paper PCR what I've done and I think that most of the other docs do the same thing and we understand that _____ narcotic PCR's are a little bit more difficult _____

Surprenant: There's a medication form that exists for the agencies that are using EPCR that is a paper form that a physician can sign and then it gets handed to the doctor so that does exist.

Markham: So we can still do that.

Fricano: As long as there is some kind of record of what we've been told to do.

(_____)

DiRubbo: That's exactly the point. Further discussion, we need to make a physician record because ideally if you get this out in the field you would like to know how many physicians are doing

the response, what are their response times, what is the length of scene time if the physician is on scene versus a paramedic and look at those. So all these issues is that when we roll out the system that there be some type of either at least a Central New York form if there is no State equivalent for the physicians to complete. So we can really look at the program.

Morrissey: John Morrissey, New York State Health Department. When we implemented narcotics many years ago, BCS was comfortable with using a script pad to sign off _____ legal valid medication order so as example if the doctor had his script pad, just sign off, quick name on top and this, that would be acceptable for BCS and the only thing that maybe _____ educate a pharmacist to accept that in lieu of a signature on the PCR, but I think that's an educational issue, as an example. Because that's typically most pharmacists won't restock unless there's a physician signature on the bottom of the PCR because we've run into that issue with standing orders for morphine. Okay, and the fact that _____ so this is going to be another one of those educational things, we're going to have cross that bridge when we get there.

Markham: This is Dr. Markham. I like Dr. DiRubbo's point, I think that there is more than just the narcotics that we should document. I think that maybe we should look at creating our own form that's a PCR form and we tear off one copy and give to the medics and the other keep as our medical record, we would send it to Central New York EMS or even the agency that we were working with stores it with their PCR. That's a real hole in the system _____.

DiRubbo: Because if you think about it in our protocol books we're talking about trauma length at scene of 10 minutes. If you have a physician on, you may find that your length at scene may be 15 to 20 minutes, then we want to look to see is that detrimental to the patient outcome or does that include the patient outcome, and starting when they release the program with good documentation from the beginning is what is going to allow this to be an actual worthwhile program and to make worthwhile decisions.

Morrison: Jerry Morrison. One question, so the physician is on the scene, they establish that physician-patient relationship at that point, can they hand off to a lower level trained ___ EMS provider to transport once they have made that physician-patient relationship.

(_____)

Markham: I think the physician-patient relationship is variable depending on what you actually do. A lot of times the physician shows up on the scene and does not develop that, just gives on-line medical control --

But legally the establishes your physician-patient relationship.

Markham: It does some.

Olsson: That is -- I think that you probably have to delve into what the legal definition is because it varies greatly.

Fricano: I don't really see that as a problem because even under EMTALA

rules a physician determines the appropriate mode of transportation for any given patient that they have. So if the doctor-patient relationship is established by virtue of a physician on scene and the physician determines that the paramedic level, critical care level or basic life support mode of transport is appropriate to move that patient to the next point --

So if it's a transfer we need to fill out the three form COBRA forms.

(_____)

DiRubbo: The physician is going to be responsible. It's going to be up to a jury and the court judge to say the degree of responsibility ___ that physician is going to be responsible once they establish themselves on scene as a CNY EMS physician for that patient during transport. They may opt to delegate that responsibility and accept the consequences of it or they may opt to transport with the patient, but there is no way around it, you're going to be responsible. If there's a bad outcome, they're going to go look for you, and you're going to have to defend your decision.

Olsson: That's correct. So three things real quick, one is there is a lot of great comments and a lot of it has to do with stuff that is beyond the concept of the policy statement so before we get too in depth into forms and all this other stuff which is important, I'd like to hold that for another time and focus on this. Clearly we've noted that there's documentation, there's transfer of care questions and the like. So my preference is to identify those major issues and then we can come back and look at these

issues once we have given them some thought. Dr. DiRubbio.

DiRubbio: By accepting this policy, will we prohibit now you from participating in any EMS that you're not approved. So if we accept this policy we need to have the approval status because once the policy says you need to be approved those who are acting in the field will have to have a way of being approved. Do you understand what I'm saying?

Olsson: So in other words an effective date?

DiRubbio: Yes, once this becomes effective those physicians who are currently in the field now have a policy saying that they should have been approved and if they're not, it's almost like a cease and desist order so I don't know when --

Olsson: That's a good point, and that's why I want you to digest it until at least the next meeting. Let's think about it and -- that's a good point.

Price: When you are talking about some of the issues surrounding some of this stuff, there's already a pretty good model out there _____. I would look to maybe _____.

Olsson: There are some models throughout the country that are doing this.

Price: As we forward with the policy, there's lots of ways to saying that. _____.

Morrissey: If I may, let's remember that there is a lot of ____ happening for a number of years where this happens

quite routinely and you have relatively few, I think we can say there's been a pretty positive impact on _____. I think we shouldn't lose sight of that, and I think these issues will work themselves out as we have with our party ____ events. Now, grant you, yes, we create emergency health care facility and we have a plan that supports and allows the physician to do that _____ to clear up some of these. I would offer that with ____ plan working through to address this and then I think when REMAC makes an endorsement will help clarify a lot of that and perhaps it's time to move on, that will be ____ plan will help flush out these things. As we do now with _____, we talked about in the past from different ____ events, certain protocols that are allowed on site physicians _____.

Unkn: A couple of things, I apologize for coming in late. This assumes that we have authority over hospitals in this policy, and I'm not sure that we do, and also if I read it right, basically, and maybe this is the way it should be that you have -- you're the only medical control physician as the regional medical director. The agency medical directors like I am can only advise.

Olsson: As opposed to—

Unkn: As opposed to providing medical direction. From a legal standpoint, I'm totally happy to shed my legal responsibility to your malpractice insurance, and that may not be the way that you really want it.

Olsson: Actually, I think you do, and I share mine with Mark Henry.

Unkn: Well, under this though, I'm an advisor –

Olsson: Which paragraph are you looking at?

Unkn: Each ALS and BLS agency within the Central New York EMS Region will have a ___ medical director. She/he shall participate in the agency's CQI program and may advise the agency providing medical care regarding medical care. But up above basically in the first paragraph of the policy you've delegated the responsibility of overseeing advanced life support to the associated medical director, da, da, da da.

Olsson: That's the current policy.

Unkn: Is that – I'm just asking really in my mind that means that you have the responsibility of oversight as an agency medical advisor I just have responsibility of advising and is that consistent with what we want and also with the laws and regulations.

Olsson: All right.

DiRubbo: Dr. DiRubbio from Auburn Memorial Hospital. I read that the same way and I actually was very happy reading that. I come from an area that we have difficulty recruiting physicians to be medical directors so the policy statement that has it as advisors and clearly delineates a very specific role for them, I think it would be encouraging for me to recruit my colleagues to serve as medical directors so I'm in favor of keeping it as it is legalese and acceptable as simple as possible because I think it will help recruit medical directors in an area where we are getting more and

more people gun shy and signing on that bottom line.

Unkn: I don't disagree. I just wanted to make sure that that was the intent of the organization to do it that way --

Olsson: I can't tell you what the intent was.

Unkn: And that may be something that we want to consider, but as I said before, the other issue is that the hospital has to provide the REMAC with a list of those oriented to regional medical director. So we're requiring hospitals, but we don't have oversight so my suggestion would be that each REMAC – or the regional authority keep that list and rather than the hospital having to provide the list, it has to be an individual physician to REMAC relationship rather than a physician in the hospital to REMAC relationship.

Olsson: Yes, is the short answer. If I understand or remember, the hospital -- a hospital that runs an emergency department that accepts ambulances has an obligation, a requirement, something to participate with the REMAC and stuff.

Morrissey: John Morrissey, New York Department of Health. 405 clearly says, the hospital has to participate in – an emergency room based hospital has to participate and provide data to pre-hospital EMS system to allow quality assurance and looking at data and _____, that's code 5 of 405, and that's an absolute requirement.

Olsson: And it's always been the policy of this region that emergency department physicians would provide on-line

medical control follow and abide by the policies and protocols. The very good question is, what if they don't?

Unkn: No, my issue is more with the orientation because I think that is very important that people be oriented quite frankly both to the protocols, to, you know, how to press the button the radio.

Olsson: That's goes back to the base station course that we developed how ever many years ago –

Unkn: Are hospitals responsible for administering that course, providing that course, and then logging the students who took the course?

Olsson: My understanding has always been that that was relegated or delegated by the REMAC to the ED directors and then it's their responsibility to see that their people did it, and then there was a time when we used to actually get direct feedback when we had a fairly stable city. My guess is that it's not being done very well.

Price: Colleen Price, CNY EMS. We just went through this about a year ago. _____ and basically what it was, we provided the materials for the office, the video tapes and slide sets to the medical director to do the in-service with the staff _____. It was ___process.

Olsson: So we will need to revisit that and contact the ED directors and readvise them what their participation is and see if we can get some kind of verification from them, what they need from us to get everybody up to where they need to be.

Kowalski: Just real quick, without ____ this is Dr. Kowalski, in Midstate REMAC makes the policy and every single base physician takes a test and is approved by REMAC. You're delegating that to the ED directors, but it's still REMAC that controls and dictates who is a medical control physician, not the hospitals, it's this REMAC.

Olsson: I couldn't tell which way your head was moving.

Morrissey: John Morrissey, New York State Department of Health. The designation of who can provide medical control to pre-hospital providers, what physician is authorized to do clearly falls to this REMAC. We have some REMACs that will not authorize EDs to provide medical control because they didn't have enough physicians trained. I think one is Star Lake up north that covers I think with the overnights with physician assistants/nurse practitioners and so they don't have that level of coverage so they have to call medical control ____ in Watertown. So it's an ongoing thing. Every REMAC does it a little differently. You've cited Utica. In Binghamton ____ process yet. Again, it's what you all want and it's a two-way street obviously here because the hospitals you have to work with to accommodate them as well so – because if you make the restrictions so hard then no facility is going to be able to give medical control. So –

Unkn: _____ just a clarification. Mid-level providers in giving medical control, this happens, what's the –

Morrissey: All right, I can speak authoritatively tonight on that – tired,

I've got to go back and read some notes. There was at one time a technical glitch in the law and I can't remember which it was that physician's assistants couldn't order morphine, but they could order benzos, and nurse practitioners could do both or it was flip flop, and I don't remember.

It's PA and narcotics.

Morrissey: PAs and narcotics, okay, thank you, it's been a while. And that is one of the limiting factors over medical control and mid-level practitioners, and again I believe that is being looked at the SEMAC, so I guess I'm a little reluctant to say much beyond that because it's in flux.

Unkn: I just asked because it is not uncommon for mid-levels to provide medical control or at least get on the radio and this essentially says it's got to be a physician.

Olsson: That has always been the stance of this region and again without getting any more into it, there was a lengthy discussion at the SEMAC and SEMSCO and it will continue to be for at least the next several years so one or two more comments and then we need to move on. Colleen.

Price: With the current protocols and the updates in May, June and July it's a great opportunity to bring all the hospitals back into it and say, you know, this is a great time to in-service your staff, here's the new protocols and it can be kind and gentle _____.

Olsson: You're hired.

DiRubbo: Can we computerize this? I have been with probably the most stable ER in this region who has now got an influx of brand new physicians and I think that the easiest way I have the books, if we can computerize this, when my physicians come on, they go with it, they print a CME certificate, and it would be easier to do and keep it.

Olsson: Where we're at with the protocol roll-out is there are several videos ___ on the policies. There should be no reason why we can't take the base station course which is very short, put that on the FuNCMeS web site along with a post test on ___ or whatever and there it is. So, yes, it's -- we're on the verge.

Surprenant: Dr. DiRubbo we've got the testing capacity in the web site itself so basically a physician, we've got it where they can just register on the web site and then take that post test so we could actually register all the base station physicians and then if we want to automate that test, they can put it right in the system.

DiRubbo: In hopes that my physicians would actually do part of the course, if you could do some kind of educational on it as well, or else you're going to have a lot of physicians out of county who will finish the post test, hand it in, and I'm not sure how much of an educational component they actually got.

There's a whole slide set.

DiRubbo: If we put the slide set as well _____ post test, and I hand them a book, my physicians will do the post test ---

Olsson: No.

DiRubbo: I know it's difficult to believe _____.

Fricano: It's only happening Auburn.

DiRubbo: I spoon feed them as much as I can and the more information I get on the computer I know the more that they will actually kind of see it in the morning when they're doing it.

(_____)

Olsson: I'd like to move on so we can get out of here before the snow flies. Blood glucometer.

Surprenant: Last July we approved a glucometry policy statement allowing EMTs to be trained __ policy statement. One of the things, instead of approving every single agency _____ the feed back ____. So far we've got Trumansburg Ambulance, Weedsport Fire Department, WAVES, Cornell EMS, EAVES, CIMVAC Fire Department that have turned in and their EMTs are able to use blood glucometers ____. Then the agencies out there, there are some ALS agencies that __ finding out that do not have the CLIA registration number, and it was brought up two SEMACs ago that SEMAC tried to get a waiver for EMS and it did not pass so all the ALS agencies or any agency out there using glucometers needs to have that registration. So we are polling seeing which ALS agencies don't have it and letting them know where the form is and letting them fill it out. We will clean up BLS as well as ALS with this policy statement. In a previous meeting we brought up the CME program and post changes _____ have a scenario base and also looking at having more than

just REMAC physicians as agency medical directors to do the course CME evaluator. So we're at the point where if you bring me back that feedback and what we're looking it, is first off there is no prerequisite for CME evaluator so we could have a new paramedic where they just got their card and became an evaluator for CMEs. What we would like to do is similar to CLIs have a requirement that you've got to have a year experience and the little that you're going to precept at or evaluate at. Then instead having the skills right in the course, trying to have – say there's 20 in a course, we've got 1 REMAC physician that's going to do some evaluating skills for 20 people in a few hour period, the thought was to have prescreen where there are skills and bring them back because previously it was done where the physician with a clinical coordinator or designee would evaluate skills, have that done so that it's not part of the course. Once the evaluator has their skills evaluated, you're an evaluator as long as you keep current on that, and the course itself, instead of an evaluation of an existing evaluator's course would actually have some educational points of how to evaluate somebody, how to coach somebody that may be weak in one area, if you can identify that when you're doing a cardiac arrest, that they're a little weak in the pediatrics and they need some more scenarios that you're able to coach them through that and make it an educational versus State evaluation where it is pass or fail. So that is a thought and part of that course would be where you run demos and scenarios and critique each other and just try to do the practice during that course. So that's what we're looking at. There is a curriculum that Dr. Olsson and Dr. DiRubbio have seen the Power Point

piece of that, but we would like to bring that back and also send this to assist the REMAC physicians since it is a small group, that there are some agency medical directors that have expressed interest in helping with the evaluator courses. I know Dr. Olsson when we discussed it, we'd like physicians that have to be active agency medical directors, taken the base station course, have either emergency medicine or peer experience and be approved by this body and then that would extend the amount of physicians that can teach this. I know Dr. Thompson has expressed interest. Dr. Cooney, Dr. Landsberg, are three physicians that have expressed interest in helping with this process. One of the goals is to try and make this a more educational process to help prevent some of the CQI cases that ____ more proactive.

Wallis: Norm Wallis, Oswego County. Susie, didn't we talk at one time that some of the CICs in the region was also going to help with that protocol and the CME's.

Surprenant: Part of – the regional trainers that we would look at besides the evaluators is look at the existing CICs and CLIs. I know Dr. Iannolo brought up the fact, but they're not taught regional specific to our evaluator course and that is a piece that can hit on specific to our protocols so we have an additional educational piece for that, would we be able to use that group as well since they've already gotten additional training to be a CLI or a CIC so that would extend the amount of evaluators that are out there and also I can't remember where the two year card came from, but extend that to a three year to match up with your existing card

right now or if you're CLI or CIC, you maintain, it's going to go to three years so I don't know where we came up with two years.

Morrissey: John Morrissey, New York State Department of Health. Just a friendly reminder, ____ is basic life support. It is educational _____ toward basic EMT courses, it is not ____ toward an AEMT criteria ____

Surprenant: That's why we want the additional piece for the ALS.

Morrissey: I understand. Just a friendly reminder before folks forget.

Surprenant: Colleen?

Price: John, one of the things that we did look at with this, is that just because you may have ____ doesn't mean _____ up until last year what _____ so we did address that _____.

Morrissey: To me, if – as an example, let's say you're an IC and you're an ACLS & PALS instructor coupled with the IC makes you a good candidate to be a CME evaluator – a better candidate perhaps is what I would say, not saying that's an absolute, but it certainly lends itself more credibility than _____.

(_____)

Morrissey: Thank you, I just want to remind people that we forget sometimes _____EMS.

Surprenant: Lon?

Fricano: I can tell you where the two year piece came as CME evaluator.

_____ and when the program, when Joe Galloway _____, when you were considered a CME evaluator as long as you remained currently certified at your level, the only time you had to come back in for additional training was if there was a change in the system, a new skill that you have to be doing, medications, protocols so that you could act as a peer review person, it was never intended to be a pass/fail scenario, it was to coach and to refresh a little on a peer review basis which is what I think it should be. When Timmy Perkins was director, he added that two year expiration date on there, when _____ and that was stated back then, well, that was a mistake, they're not suppose to expire, but all CME evaluators can call in when the system creates another tier that they're going to have to be responsible for so that's where that came from, it was done unilaterally by Tim Perkins, it just never got corrected.

Surprenant: Norm Wallis?

Wallis: Just one last comment. Norm Wallis from Oswego County. Though I hear where Lon is coming from, I do think, however, it is a good thing to have an expiration date on it just so that we can ensure that people that are out there monitoring the people in our system are also certified or competent themselves. So I think a three year might be a positive thing, too.

Surprenant: Colleen Price?

Price: One of the things that we did look at was you're still required to be a provider standard, which means you're going to go in front of another evaluator at some point and be evaluated to

maintain your standing as a provider so there is an ongoing evaluation _____.

Fricano: Twice a year.

Price: Yes, because you're going to be required ____ you're just going to have the additional responsibility _____.

Surprenant: Dr. DiRubbio.

DiRubbo: I'm faced in Cayuga County with by the end of June having to recert and maybe new cert some new CME providers. Looking at what has been released out there, and the way I'm thinking about planning it – is that people who are previous CME evaluators to have them come into the night with their skills signed off by a peer that says that they have demonstrated these skills prior to coming into my class, having less sure which is a didactic session that's proposed more on teaching, talking about adult learners, talking about the needs of the providers, at the end of that day, if they have been previously a CME evaluator, they have a sheet that's signed off by one of their peers saying they had successfully done that and they attended the class that they would continue to be active provider – CME evaluator. Any one going through a new CME evaluation who came to the class subsequently by either myself or someone that I appointed would go through those skills when they completed and demonstrated their skills after the lecture that they would be a new CME evaluator, does that seem in accordance with REMAC the way that this should be approached as we continue to kind of solidify how to go through it?

Surprenant: With the roll-out of the new protocols and the _____, the goal is to get every evaluator that currently is active get them through so we can have them ready or – close to the semester and then we can concentrate on the new group and say based on providers that have gone through this, it's one of the things with the new roll-out every evaluator is going to go through updates because there are way too many changes and if someone is not willing to do that time, we're going to have way too many CQI issues. So the thought is, let's get everybody through, see how many we need and then we can sit down with each county and say how many more evaluators do you need for your agency – for your county and then we can concentrate, because we have more people that can help teach the original course and get that taken care of.

DiRubbo: The CME evaluators are not new evaluators before the semester which I believe is June 30th?

Surprenant: Yes.

DiRubbo: And where is there a complete list of all the CME skills and are the highlighted protocols so those can be emphasized on the lecture period. I don't know where to get that list. Where do we get that list?

Surprenant: I can get that for you. Because you and I are going to be dealing _____.

Olsson: April 30th.

Surprenant: It's already on my calendar. And I've actually got one for Dr. Fullagar, too, so we've already got – identified that, Cayuga needs one, and

Onondaga needs one, so we'll have more. But the goal is to let's get the new – the existing evaluators through this and with the new protocols because with all the protocols and all the stuff there's a lot of changes that are coming down and we need people to be proficient at that. Any other comments?

Olsson: Unless there's a major burning issue, I will enter a motion to adjourn.

Move to adjourn.

Second?

Aye.

Olsson: All in favor? Thank you everybody. July 16th at 1700 hours.