

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

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

Staff

Eckstadt, Tamara		X	Non-Voting	CNYEMS Program Administrative Assistant
Jones, Jeff	EMT-P		Non-Voting	CNYEMS Clinical Consultant
Price, Colleen	EMT-P	X	Non-Voting	CNYEMS Clinical Consultant
Surprenant, Susie	NREMT-P	X	Non-Voting	CNYEMS Program Executive Director

Guests

Melissa Martin  
Brian Calley  
John Morrissey

All right, we're on.

Olsson: Okay, we'll go ahead and call the meeting to order, please. July 8 meeting of the Central New York REMAC. A couple of housekeeping issues. Once again, speak clearly and loudly into the microphone and announce yourself with pride. Microphones do pick up comments so be careful what you whisper in the background. Given the nature of some of the events of the last couple of months, we are going to need to go into executive session and I would like to start that by 6 at the latest so I'd like to move through the agenda as best we can. So just kind of keep that in mind. April 8<sup>th</sup> minutes were sent out electronically. Any concerns, questions, corrections? Move to accept. Don't care.

Motion to accept.

Olsson: Second. All in favor?

(Ayes).

Olsson: Opposed? The SEMAC report. The SEMAC and the SEMSCo met May 25<sup>th</sup>. Highlights, Ketamine was passed and is on the formulary. Mercy Flight has submitted a protocol for the use of Ketamine and that was passed, and we don't have an implementation date for that yet. Fentanyl, the agencies that are using fentanyl, remember that you have a quarterly reporting to the Bureau. There are several hypothermia studies. Basically hypothermia after return of spontaneous circulation. Specifically New York City, Albany and Buffalo, and there's been ongoing discussions for the last two or three or four meetings whether these are pilots, whether they're research, whether they're protocols, and there's no good answer. And there's no good answer as to what if another region wants to do it and what I was told initially was because it's a pilot it's limited to those particular agencies already approved. So be aware just for research background that that's being done. There's a national minimum standard equipment list which can be found on the Bureau website. We took several protocols to the medical standards and SEMAC and SEMSCo which we thought was going to be very straight forward, it wasn't. In the transfer protocol, we basically corrected a typographical error that went back to 1998 that was never found until fall of '09. That was passed without an issue, however, at medical standards they picked up on the fact that we allowed propofol to be used for interfacility and after about a 30 minute discussion in medical standards it was decided that you had

to be a licensed provider to utilize propofol and it was taken out of the transfer protocol. However, when we got to the SEMAC, they said, somebody else said no, you don't have to be licensed, you can be certified and after another 20 minutes it was put back in and it wasn't part of the changes anyways. What did come out of that was that we did develop a transfer form and it was recommended that on the physician's signature that they also add the physician's license number as a method of tracking which is reasonable so they'll do that. The two protocols that we did take were for CPAP and those were very uneventful. They were passed virtually unanimously and immediately, and they did recommend that if you are transporting a patient and you're using CPAP that you call the emergency department and let them know. The CDC came out with a new trauma triage \_\_\_\_\_ and these were adopted by the SEMAC with the addition of pediatric pulse rate. Again referring to the DOH web site. North Country brought for discussion a taser removal policy. That was sent back to the region for discussion and rewrite. I don't really want to comment more on that because I think it's a bad idea. STAC, they also looked at the new trauma triage criteria and there's a trend at looking at physiologic criteria. This will be published on the Bureau web site. There was also a recommendation that since the CDC already has educational material relative to the trauma for the general public that that be utilized rather than developing something new. The Family Medicine Act was relative to the MOLST. There is a new DNR portion of the MOLST that will be coming out relatively soon. It is an attempt at simplification for EMS and it pretty much condenses the second page into just a few choices and when that gets farther along that will come out. From the EMS office, the blood transport doctrine, for the lack of a better word, is in the Legal Affairs Office and in turn had to go to the Governor's Office, then it goes to the State Register for 60 days for review and comment and then will supposedly go to the Commissioner for signature. State EMS Office may furlough workers so the only thing you may get is a phony answering person. Discussion regarding on-line medical control, State DOH policy 95-01 says it must be a physician. The Governor has signed legislation stating that a physician extender may perform any function that a physician performs with appropriate guidance and supervision. This now apparently is setting up a battle between what's regulation and what's policy, so that's up in the air and more to come. The QI Committee, they're looking at electronic PCR's as far as content, vendor, version 6 is on the drawing board. STEMI, they're identifying and looking at various QA data points to look at hospital outcomes. There's still confusion out there as to what a STEMI center is and what it's going to be designated as, etc. What they said was, where did I write that, if you can do – oh, yeah, all PCI capable hospitals are STEMI centers. What has not happened is there is no protocol like we have for stroke centers. There's no official notification like we have for stroke centers. There was going to be something defining the criteria more than if you can do it you're it, and that has yet to happen so more to come. Patient care restrictions, if an agency identifies cases where a provider is found deficient in skills and the agency restricts the provider, then that restriction can carry over into other regions and that's up to the individual regional QA/QI to determine how to do that. There's a device called a Resqpod that some of you may be familiar with. FDNY has taken it off all their ambulances because they noticed a decrease in survival rate when using it. There was a question on mutual aid. The grievances approved by the local REMSCo, agencies should respond as agreed. There was a motion for the Bureau in concert with OHIP to send a letter to all agencies clarifying and encouraging the use of mutual aid response. So you should still do it. Assembly bill 8009 is in reference to accidents on the Thruway and it allows for unrestricted EMS access for ambulances so that they shouldn't have to pay the Thruway toll to get to an accident scene. And that was the long days of SEMAC. CQI report, Susie.

Surprenant: We'll cover the CQI report in Executive CQI so I'll go right to the Program Agency report. We just held a regional CQI meeting and in there we had recommendations for three regional awards, one for TLC EMS and SUNY Cortland for a cardiac arrest save, one was for Rural Metro

and Syracuse Fire Department for a cardiac arrest save and also a third for Virgil Fire Department, TLC and Cortland Sheriff's Department. Fourth is NAVAC by Dr. Markham paperwork to be forthcoming. We also did as the Program Agency we have a course sponsor to run all the CLI and CIC instructor courses so our renewal form went into the Bureau and we're also holding an instructor coordinator course that is scheduled for November 13<sup>th</sup>, 14<sup>th</sup> and 16<sup>th</sup>. I want to thank St. Joe's and University Hospital, Rural Metro and the Council for sponsoring and holding the EMS Symposium. There was 112 people that attended. It was very well attended as this is the third year that it has been held and the response from that was very beneficial to the providers. On that as well, Crouse will be hosting a fall EMS teaching day on September 30<sup>th</sup> and they will be giving us more information that we will put on the web site and send it to providers so that there will be two opportunities this year for CMEs within the region sponsored by the hospitals. We are also, since we are getting more requests from hospitals to post information that's pertinent to providers, we're actually going to be developing a web page on our site similar to what we did for medical directors for hospitals. It will have a section for each hospital so if there is any information that you would like to present to providers we will be posting. I already have two things for Crouse to go up on that. So if there is any more, we've also told the ED managers to send it our way and we'll get that out \_\_\_\_\_. That's it.

Olsson: Okay. Any questions for Susie? One noted correspondence, Mercy Flight has established a base at the Watkins Glen International Raceway and basically 9:00 am to 6:00 pm, 7 days a week, covering that portion of the region. Pursuant to Article XXX requirements, we're required to read the suspensions, Thomas Malley suspended one year in violations of part 800 section 16, Julius Franquet revoked for violations of 800.15, 16 (a) and (b), James Hunter suspended for three years, they will stay all but the first 90 days of the suspension, placed on probation for three years, civil penalty of \$2,000 for part 800.16, Joseph Garone is revoked under part 800.16 (b) and (d). Okay, old business?

Surprenant: Blood glucometry as we stated in our previous meeting, any new agencies that put the paperwork and we deem it complete will be brought forth to this body. We have had Navellis EMS, Aurora-Leland Fire District added so that makes 15 agencies that have put in paperwork to do blood glucometry by the basics within the region. Dr. Olsson has already covered the protocol for CPAP. We do have one device, the Blujniak, that is being considered by Manlius and we presented that at the regional meeting and that any new devices that agencies will be using will be brought forth before this body so you're familiar with the devices that will be used prehospitally. EPCR update, we had two more agencies go electronic since our last meeting. That was Four Town and also Menter Ambulance so that brings us over 60, close to 65% electronic within the region. The other thing that will be changing is the State is developing a platform as the vendor that will accept all the electronic data from the regions and at that time when we change they'll be NEMESIS compliant and they will be giving us the data dictionary with the new data points and as soon as they approve that with the vendor they will be giving it to the regions so that the REMACs can look at that to make sure that all the data points for patient care is documented and if there is more that would be added this body would develop a policy statement \_\_\_\_ for this region. So I'm hoping that we have that for our October meeting. All right.

Olsson: All set? Under new business. We had an application from Dr. Nanovati from Lafayette from the last meeting and it was incomplete and we sent him a letter outlining what we were looking for and we have not as yet heard back so we will need to track him down and find out what's going on. We received an application from Dr. Christian Knutsen who is emergency medicine here at

University and he meets the minimum requirements for medical center direction. Do you want to pass that around?

Surprenant: Sure.

Olsson: Question?

Iannolo: This is Dr. Iannolo. What agency does he want to be the medical director for?

Surprenant: Currently there are none open, but the thought was since we have agencies calling on a regular basis seeking medical directors and most of the physicians here in this room their plates are full the thought is we've got a physician that meets the requirements that we have another physician to add to that, we would be able to give your names and this other physician more agencies to select. We're doing it a little differently, but since we've having more agencies that are either losing their medical directors, seeking another one, we have two that are holding, pending, Lafayette, \_\_\_ approval of the other physician, and if that doesn't happen, then we may need to fill those two positions.

Olsson: You could almost say we're planning ahead, proactive. Dr. Knutsen is also on one of the EMS response physicians as well. All right. ALS upgrades.

Surprenant: We've got two requests for ALS upgrades, one for Marathon Area Volunteer Ambulance and they're requesting to put in service an ALS fly car to better serve the Greater Marathon community. They recently removed their third ALS ambulance for service and would like to put an ALS fly car in its place and their goal is to establish rapid response ALS using their career paramedics to respond to their area and any surrounding areas that request it. They will be equipping the ALS fly car according to part 800 and the minimum equipment list and they know that this is pending this decision here as well as a successful inspection according to the minimum equipment list. They do not have any pending CQI issues. Let's see, they're also serving southern Cortland and northern Broome Counties. The second one is for Southern Cayuga Ambulance and they wish to upgrade from critical care level to paramedic level ambulance. They currently run one ALS ambulance and their medical director is Dr. Mary DiRubbo and they currently consist of two paramedics, two critical cares and three basic EMTs and they have no current CQI issues within the region.

Olsson: So what we're asking for is approval by this body pending the acceptable remainder of the paperwork and documentation to allow the two upgrades.

Iannolo: Dr. Iannolo, motion.

Olsson: Second?

Second.

Olsson: Any discussion? All in favor?

(Ayes)

Olsson: Opposed? Carried.

Olsson: Barb, would you care to do the pleasure since you're present and continue your report on the Auburn Memorial ED that you gave such a nice report at the previous meeting.

Perkins: Barb Perkins from Auburn Memorial Hospital. We are still seeking a permanent nurse manager of the emergency department. I am still the chair in the interim. We have change in physician coverage effective this coming Monday, the 12<sup>th</sup> of July. We are going from physicians who have been employed by Auburn Memorial Hospital to the Pegasus Emergency Management Group. It will be a private group running our physicians out of the ED. They will be retaining four of our current emergency department physicians and the other two physicians right now working with us will Dr. Jeff Ruzik and Dr. John Halterman. Part of their implementation package is also a physician orientation which will include the EMS protocols. There is a book in the department. Susie is going to provide me with some additional books for the physicians so that we can insure that there is adequate and appropriate medical control coming out of Auburn ER. Dr. Iannolo is one of the physicians who is present here tonight is also going to be remaining on staff at our facility. Thank you.

Olsson: Thank you. As some of you may be aware, there is a shortage of epinephrine and other various sundry medications. We did send out a couple of memos regarding alternate ways of diluting and getting around the problem. The major attempt was to make it as simple as possible. Yes, we realize that you're going to end up with 0.9 mg instead of 1, but our concern was that if you have a single provider at 3:00 in the morning who's trying to draw out 1 ml or 5 ml and draw up something and stick in a bag it's going to create issues. So that's the gist of that. That was the clarification of that. So those are the two, dopamine and epinephrine. Magnesium and dextrose are also on the horizon. We're not sure too much what's going on in that arena, however, for further comment.

Morrissey: Today Dan Broedel from Utica advised that they are currently out of D50, Lasix is an issue, Narcan is an issue, epinephrine, they've got a lot of 1 ml vials, but they're running short of 30 ml vials, they're just about nonexistent. So it's getting – it's to the point where in the agency each drug bag is having difference stuff. One thought that they're doing or suggesting to the services, if you do alter what is the normal concentration, they're suggesting putting notes on the bag or just, you know, reminding people that this is not carrying the normal stuff and please review what's different about it than what they are used to. I just share that with you as a point of information.

Olsson: One of the other comments we made at the previous meeting today is the minimum equipment list is going to by default be altered. We're not going to be able to come out with a memo every week that says because of the shortage. As far as epinephrine goes, the recommendation was as long as you carry at least that number of milligrams, you can dilute it and mix it as needed. But be aware of the fact that it is happening and crews are going to have to be very, very diligent and look at what's in the bag, maybe more so than normal and we just can't stress that enough. Dr. Iannolo.

Iannolo: Just two questions have come up primarily from TLC. The first is that they're trying to a milliliter into a 10 cc syringe. You're kind of over distending the syringe and having a difficult time possibly getting the full milliliter in and if it overflows, you may be getting even less than the anticipated dosage that you intended to give. Modification of the protocol at least a prefilled 10 cc syringe would be to express a cc from the syringe first before trying to put the cc of epinephrine 1:1,000 in the syringe. The second question is, is the region going to require that if a 50 cc med bag is used to dilute the epinephrine are we going to require that the agency label the med bag. To me, it just seems like an accident waiting to happen. We have a normal saline bag kicking around in the

commotion of the resuscitation attempt and you have four more doses of epinephrine in that bag which then potentially could get reduced for some other purpose.

Olsson: Having been a standard practice at least in the back of my mind to always label the bag, it never occurred to me, but we'll certainly send out, yes, we'll do that. It didn't occur to me. We'll do that. The prefilled syringes will go to 11 cc so it's possible. Again, if you have the providers and you squirt out 1 cc or 1-1/2 and still get it into a prefilled, let would be desirable, sure. But again our intent was to try to keep it as simple for the 3 o'clock in the morning single provider who's trying to do everything. Part of our discussion again earlier today was to do another update after this meeting with such things as labeling the bag, removal of the 5 cc out of the 50 or the removal of the 1 cc out of the 10 and just kind of tidy up the loose ends that would come out of this meeting, sure. Since I skipped over any old business. Any new business? Warren.

Darby: The Vital Signs this year is going to be down in New York City. The last weekend of August and I would like to announce that the EMS Physician of the Year is our own Dr. O.

(Clapping)

Olsson: Thanks everybody. Any new business? Any concerns or do people want to go out and enjoy the heat? Do you have anything else? If there's nothing else, then I'll entertain a motion for the body to adjourn except for the physicians and I'm sure we'll have an interesting evening. All in favor of adjournment except for the physicians. Opposed? Have an enjoyable summer everybody and be safe.

Respectfully submitted,

Tamara Eckstadt  
Administrative Assistant