REGIONAL EMERGENCY MEDICAL ADVISORY COMMITTEE (REMAC)
Serving, Cayuga, Cortland, Onondaga, Oswego & Tompkins Counties

Meeting Minutes of August 14, 2014

Name	Title	Present (X)	Status	Representation
Members				
Adkisson, Steve	RN		Non-Voting	Upstate Medical University – Trauma Peds
Brenner, Jay	MD		Voting	Community Gen Hospital – ER Physician
Butler, David	EMT-B		Non-Voting	BLS Provider Cortland
Cater-Cyker, Mitch	EMT-P	X	Non-Voting	CNY EMS Clinical Consultant
Cooney, Derek	MD	X	Voting	Agency MD - CAVAC, Dewitt, EAVES, NOCA, Rural Metro
Cooney, Norma	MD		Voting	St. Joseph's Hospital - ER Physician
DiRubbo, Mary	MD		Voting	Agency MD - Southern Cayuga Instant Aid
Eckstadt, Tamara	Staff		Non-Voting	CNY EMS Administrative Assistant
Emmons, Jerry	MD		Voting	Oswego Hospital – ER Physician
Flynn, Shawn	EMT-CC	X	Non-Voting	BLS Provider Tompkins
Flynn, Susan	EMT-P	X	Non-Voting	ALS Provider Tompkins
Fullagar, Chris	M.D., FACEP	X	Voting	Veterans Admin Hospital – ER Physician
Hilkert, Melissa	RN		Non-Voting	Cayuga Medical
Hogue, Troy	EMT-P		Non-Voting	ALS Provider Onondaga
Iannolo, Patsy	MD	X	Voting	Auburn Community Hospital – ER Physician
Jorolemon, Michael	D.O., FACEP		Voting	Crouse Hospital - ER Physician
Joslin, Jeremy	MD		Voting	Co-Chair Air Medical Services Committee
Koch, Drew	D.O., FACOEP		Voting	Emergency Dept. Physician Cayuga Medical Ctr.
Knutsen, Christian	MD		Voting	Agency MD – Fayetteville FD, Liverpool FD
Landsberg, David	MD	X	Voting	Agency MD - SAVES
Mangano, James	MD		Voting	Upstate Medical University – ER Physician
Markham, Joseph	MD		Voting	St. Joseph's Hospital - ER Physician
McGarrity, Bill	EMT-P	X	Non-Voting	CNY EMS Clinical Consultant
Merrill, Peggy	EMT-P		Non-Voting	ALS Provider Tompkins
Morrison, Jerome	RN		Non-Voting	Upstate Medical University – Trauma Adult
Morrissey, John		X	Non-Voting	BEMS
Olsson, Dan	D.O., FACOEP	X	Voting	Regional Medical Director
Price, Colleen	RN/EMT-P	X	Non-Voting	CNYEMS Clinical Consultant
Olsen, Steven	RN		Non-Voting	Oswego Hospital Emergency Dept. Nurse
Rathbun, Joseph	EMT-B		Non-Voting	BLS Provider Oswego
Seth, Naveen	MD		Voting	Agency MD – Minoa, Kirkville FD
Sowles, Donna	RN/EMT-P	X	Non-Voting	ALS Provider Cayuga
Stack, Kelsey	MD		Voting	SUNY Upstate - ED
Surprenant, Susie	NREMT-P	X	Non-Voting	CNYEMS Program Executive Director
Tzetzis, Spiro	MD		Voting	Agency MD – Syracuse University Ambulance
Wallis, Norm	EMT-P		Non-Voting	ALS Provider Oswego
Wirtz, David	M.D., MPH		Voting	Cortland Memorial - ER Physician
GUESTS				
Ray Thielke	BEMS			
Zhu Yi rong				

Carl Oiaeden				
Erin Wirths				
Chris Tarski				
Ann Smith				Lifenet of NY

Olsson: Okay, we had a little snafu so we're going to go ahead and start the meeting. When the food shows up, then we will go off camera and go from there. We will call the meeting to order of the Central New York Emergency Medical Services Regional Medical Advisory Committee and it looks like it is 1715 hours. Usual housekeeping stuff. Make sure that you use a microphone, identify yourself prior to that, and be wary of any extraneous comments as they do get picked up and are recorded. We'd like to welcome, we have two physicians from China who are here visit. We would like to welcome them –

Nurses, okay.

Olsson: Well, then _____ . We have a couple of new physician from Upstate as well and we will move forward with the agenda and the meeting minutes from May 8th were sent out electronically and I would ask for any additions, corrections, motions to accept, etc. Okay. I see the usual lackluster. Dr. Landsberg , Dr. Iannolo all in favor of passing. Okay, approved. I will note for the record that based on our definition of a quorum from several years ago that being the number of physicians present equals a quorum. We have a quorum this evening. SEMAC, SEMAC met in June and while I thought I was taking pretty good notes at the time, a couple of areas that are a little sketchy, so when Susie gets back I may ask her to fill those in for me. What came before Medical Standards and the SEMAC were these Central New York, North Country, Midstate, AEMT changes that were reviewed and voted on here. The only real change was they wanted us to change secondary to supraglottic airway and I was just as vague then as I am now and it may be Ray or John can enlighten me or remind me because this would seem to eliminate the Combitube, the King airway is becoming very popular throughout the State and one of the discussions that's been ongoing is the fact that there are two, at least two different styles or types. There's the King and something and then the King LT and the LT version has not been approved by the FDA so the King airway and the Combitube and intubation are being taught as part of the new AEMT curriculum. I don't remember what anaphylaxis was about. There's a general ongoing discussion that somewhere down the road, Levophed will be naturally replacing dopamine which actually everybody was happy with. Blood glucose levels continue to plaque us. We thought several years ago the last time we had this discussion as to what the blood glucose minimum level was and everybody agreed on 80. Low and behold, when the State brought out the – what is now the opiate hypoglycemia overdose protocol it was 60. So at the last SEMAC once again, they have decided that the minimum standard glucose level is going to 60 for everybody throughout the State. There was a discussion about inhaled glucagon for hypoglycemia. Initially everybody thought, yea, maybe this looks good. They talked about it for an inordinate period of time and they came to the realization that it doesn't really work and don't bother even talking about it any more so that was the end of that. There was a discussion on nitroglycerine paste for pulmonary edema. Seizures, probably EMS should notify the hospital whenever you have an active seizure patient. Makes sense. I had not looked at this, but Monroe-Livingston is doing a lot of their training with vod casts, video on demand. To me it's a glorified YouTube thing, I don't know if anybody has had a chance to look at that. Their new heart protocol, they do have more than one person with the left ventricular assist device in their region and I believe that's the gist of the training video. Altered mental status, that used to be called the opiate overdose protocol and it's now the altered mental status protocol for the BLS, and they are reporting that there are 150 new naloxone services, that's what the State is referring to agencies, police, fire, EMS that are following the BLS naloxone protocols. We've talked about how to report the use in Central New York and we're still trying to figure out some way of establishing data collection especially when we're looking at law enforcement who uses it. There's a CPAP demonstration project that is ongoing through Finger Lakes and the gist of that is BLS providers doing CPAP. Very low usage most of the time. ALS providers are doing CPAP and the BLS folks kind of get bumped out of the way, but they're still looking in continuing on that. There was a discussion about bleeding and hemorrhage treatments and training classes, didn't make a lot of sense to me then and doesn't make a lot of sense to me now, but they're going to develop a tag. Do you remember, John, what that was?

Morrissey: No.

Olsson: All right. The State is changing their email addresses. Their current email addresses will be valid

until the end of August maybe. After that it will be first name dot last name at yada, yada, yada, which does mean you have to have the correct name so good luck with that. The next CIC class is August 18th in Albany. Testing, Smart Phones continue to be an issue with cheating and the course instructors have been instructed to be very weary and watchful. CME courses are being audited throughout the State. Most of the problems seem to be around paperwork issues, having the right people in the right classes for the right length of time and actually taking the class that they say they're taking. The State will be levying a penalty of 50% of the course fee that's paid to the instructors so that's fairly hefty. New course exam dates are in place through the end of August. Anything after that is up in the air. I believe that has to do with how they are contracting with the testing services, although I see we're about to get a comment from the back of the room from our State representative.

Morrissey: Yes, the issue is the late payments and the contractor is trying to work through that and at the moment, yes, we are on kind of a hold _____ .

Olsson: When the tests are taken, there is a turnaround of 38 days. Their target or time turnaround in the future is going to be 16 days for the short interval and then hopefully down to 11 days. Return of spontaneous circulation with hypothermia, there was an article that came out on November 2013 that said it really didn't do much benefit. The latest FDNY data is also showing not much in the way of benefit either. They're not sure why the survival has improved, whether it's due to hypothermia or people are just doing better CPR. So FDNY is still looking at their data and phase 4 or some such thing of their hypothermia study. So I'm sure there will be more to come on that. Lee Burns announced that there's a new Health Commissioner at no detriment to Ms. Burns, but she said unless you've been living under a rock for the last few months you would have known we have a new Health Commissioner. Well, I don't know about you guys, but I've really been living under a rock for quite a while because I had no idea that they had a new Health Commissioner. Any way, Dr. Zucker who is supposed to be a nice guy and knows a lot of stuff has taken over, they've hired two new staff, one in Albany, one in New York City. The current DOH budget is more than $100,000 short of their prior budget so they're having some issues with that. That's based on the budget that you see listed there. Article XXX has always been a topic of discussion. We know that it's been attempted to be lumped in the budget, however, as near as could be discerned from the meeting in Albany it's not going to be placed in the budget, however, the Governor and other individuals are still looking to make changes within Article XXX. Exactly what those changes are, how they will affect all of us is anyone's guess. Freestanding emergency departments are still making strides. There's one in Lake Placid and Rochester has one that's operated by Strong. The official title is North Country Health Systems Redesign Commission. The public web site reportedly has the final draft and exactly how EMS is going to fit in with the freestanding clinics is unknown. They believe it will include some form of community paramedicine, but that is still on the drawing board and is also up in the air. There is currently a QA/QI Committee that meets in Albany, however, they have not had a meeting recently. They have not had an agenda and according to Ms. Burns if that continues then there will not be a committee. The blood issue is still in the Governor's office. It was approved by committee back in 2009 and 2010. Nobody seems to know why it hasn't been signed. The best information is that it has been on Governor's desk for months, if not a year. There are services that have transported blood and blood products without appropriate nursing personnel and they have been cited, fined, etc. So once again when you are a provider at a facility do not send blood or blood products without a nurse. Paper PCRs are not going away, they're just getting bigger. The current revision is estimating 8 to 12 pages, maybe 14 pages for those that elect to not go electronic. They will not be printed by the State. They will give you a PDF that you can download for your own use and print and fax/scan to those who get the data. Stroke, the State's going to be looking at hospital collection data and this will include EMS notification and exactly what information is relayed to the hospital, exactly how they're going to collect that data I don't know, but certainly the electronic medical record would make that a lot easier. STAC, they completed the initial 40 consultative visits and as of June 2014 there were three level 1 trauma centers approved, Upstate, Strong and Southside Hospital down on Long Island. They are also looking at the level 3 centers and what information was relayed to the SEMAC was trying to figure out what type of patients will go to a level 3, and how it's going to apply particularly in Central New York. There are two level 3 trauma centers, one in Newburg and one down in Orange County. Community paramedicine project continues to be a topic of discussion. A draft paper is supposedly going to be presented at the next SEMAC next month and you could see it's going to talk about establishing the need, how it's going to interact with Article XXX and the roles of all the players involved so we may or may not know more of that – about that in a month or so. Okay, all right, moving on, we have to read into the record violations of Public Health Law Article XXX and the first is Nicholas Barbu,

Dix Hills, New York, his certification has been revoked as of February 2014, violations of part 800.16(b). We have Gaby Day, let's see, EMT suspended 1 year, 30 days actual suspension. The balance of that has been stayed and that was for violation of part 800.16(e). Okay, we'll move onto Executive Report.

Surprenant: CQI report we will be giving in Executive Session of the REMAC.

Olsson: Which I forgot to mention we are going to have Executive Session.

Surprenant: On a good note, the State has paid of all contract vouchers to date so we're in good shape financially than the last two years running so the nice thing is that the State's financial system at least at the program agencies are seeing a flow of funds coming in on a fairly regular basis now which is good. We did offer instructor coordinator course in June that was well attended. Thank you Paul Cousins and John Morrissey for making that happen. There's also an EMS teaching day coming up in the fall, September 30th at Crouse. And speaking of paper PCRs, we are still in the holding pattern with sending those to the State. The key punch contract has still not been assigned so we've got paper PCRs sitting in our office since October of 2012. So the good thing as each quarter goes by one of the things I have to report to the State is how many paper PCRs and electronic are coming. Last quarter 95% of our PCR volume was electronic which is great. The fiscal year that ended on June 30th we actually had 168,000 PCRs coming through either electronic or paper. So that represents another roughly 8,000 more calls this year than I have seen come in so thank goodness we are in electronic mode most of the agencies, otherwise you wouldn't be able to find me in that office because we were be overrun by paper PCRs. So we're hoping that – when the contract is signed, that we will start eventually getting rid of what's backlogged in the offices. Dr. Fullagar will cover more on AEMT protocols, but we are getting ready for that roll-out by making the appropriate changes to the mobile application as well as the protocol books and the new equipment list will be reviewed for approval at the other new business. The other thing is currently we have seven ILS agencies that will once everything is ready for the AEMT protocols roll-out they will either have to decide whether to go to AEMT or downgrade to BLS. If they do down grade to BLS, they're going to have to surrender their operating certificate, they will lose their agency code, and they will have to reapply as a BLS/first response agency and get another agency code. So we will work with them and make them well aware that that has to occur. I would also like to welcome Mitch Cater-Cyker. He is the new clinical consultant for Oswego County. He has joined Bill and Colleen and he's already getting his feet wet. Dr. Cooney, I don't see Dr. Cooney.

I think he's still upstairs.

Morrissey: Susie, you might want to just talk about the electronic PCR situation that we've been working on.

Surprenant: That is coming down the road under (b) on New Business.

Morrissey: Thank you.

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Olsson: I don't see Dr. Cooney. Air Medical did not meet today. Education, Dr. Knutsen. I don't see Dr. Jorolemon.

Surprenant: I have a quick one on that.

You have a quick one on that. All right, we'll do Research and then we'll bring up young Dr. Fullagar to bring us up to speed.

Surprenant: Dr. Jorolemon is on vacation with his family. We have completed the data collection for the STEMI study and that concluded on June 30th so we're getting the rest of the data from the four hospitals. We've got three of the four that we needed final data on. Once that occurs then we will be looking home data that's come in over the past year.

Fullagar: Hi, everybody, my name is Chris Fullagar. I'm here to talk to you about the Protocol and Policy Committee, we've all been very busy lately. What we are going to talk about today are some of the updated policies that we've done now. What we've done at this time is although the difference in how we've done it in the past. We now have a Policy and Protocol Committee. So what the committee has done is to go through a lot of the substances, things that come up with the word smithing, to come up with the discussions over the last few weeks and so what I'm going to do today is to go over what those changes have been and then the only thing that I'm going to need from the body as far as a vote is either aye or nay. So we don't have to go through each line and talk about all the nuances here. But if you have questions I will be happy to answer them and then at the end with the blessing of Dr. Olsson we'll entertain a vote to either accept or not. If these do not pass, then we will go back to the committee to try to formulate something that will, but in an effort to try to streamline the process at the

meeting itself and to move a lot of the substance of the discussions to a time in which we can spend more time doing the research and the leg work in order to make more appropriate policies and protocols. So the main one of substance that we spent a lot of time on are the requirements for the physicians. That includes everything from on-line medical oversight to agency medical directors to physician responders, and essentially what we've come up with are different roles that a physician can have. The first one of course is the on-line medical control physician. Essentially this is a physician who provides on-line medical control via the radio. It applies to the physician only while they're working at the receiving hospital and they are approved to provide orders to EMS personnel on the radio. The requirement for this physician of course is a valid license or an appropriately credentialed resident physician operating under the supervision of the attending physician. All the residents that do this before they are authorized to do so complete the base station course which is done at the beginning of their second year, and the physician must be practicing in the emergency department when providing medical oversight. So for this level the doctor only has this authority while they're actually working in the ED. There are other levels which we'll address the physicians operating on, but this particular level the physician has to be in the ED. Of course, they have to complete the Central New York Base Station Physician Course. The next is the BLS service medical director. Yes, sir.

When do we get a chance to ask questions at each section or all at the end?

Fullagar: We can ask questions now.

There are certain facilities that the doc is not necessarily present in the ED, but may be covering the ICU or doing something else and there's a mid-level provider in the emergency department.

Fullagar: A great question. That is not addressed by this protocol. This protocol is only for the physicians. So what we're trying to do with this protocol is to establish the minimum requirement for the physicians. The issue of nurses or PAs or other people who give orders is an issue much bigger than this region and I know that it's been discussed at the State level a few times and that there are many facilities that don't have any physicians on scene and the nurses give – or the PAs will often times give orders in those facilities. We specifically limited the policy here to address the requirements only for physicians. The practice of having PAs and nurses answer the radio we're going to leave to the State at this point.

Does that answer –

Sure, so we're not voting on that tonight.

Olsson: What you're talking about is more of a hospital issue and as Chris said it has been discussed ad nauseam and there's no agreement and I'm sure it will continue to be discussed especially with the advent of the freestanding emergency departments. This is a REMAC policy just to govern us.

Fullagar: Okay, any other questions on that? The next one we have is the BLS service medical director and this applies to any service medical director or associate or assistant medical director of a BLS agency. For that the requirements are fairly basic in that they have to have a valid New York State medical license, they have to complete the Department of Health form which is 4362 and under that they will have to affirm that they understand what the responsibilities are, including the provision of direct medical oversight on a regular ongoing basis, in-service training, review of agency policies that are directly related to medical care and familiarity with the applicable SEMAC and REMAC treatment protocols. That verbiage was taken directly from that verification form so no other interpretation was made there. In addition, they also need to complete the Central New York EMS Physician Application Form which we have here at the region and timely before they are approved as a BLS service medical director, they have to have the approval of the REMAC which is what we have been doing pretty much. Any questions on that?

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Fullagar: Okay. All right, the ALS service medical director is a little bit more involved. This applies to service medical directors or associate or assistant service medical directors of an AEMT or an ILS agency until 2015 or higher. So AEMT, critical care or paramedic. The requirements are a valid New York State medical license, board certified or board eligible emergency physician or a physician board certified or board eligible in another specialty with significant emergency medicine or critical care or EMS experience so what we are looking for here is we are not necessarily excluding everybody except for emergency physicians, but at the same time we want people to have a working knowledge about what it is that they're going to be doing. They're going to need a DEA license because they may need to

order controlled substances and then they have to meet the criteria that the BLS medical directors have by completing the DOH form, the regional form and then being approved by the REMAC. Any questions about that? Okay.

Chris, do they need the base station course?

Fullagar: Not to be a service medical director, okay, but physician responders are going to be different. So for the physician responders we have two types of physician responders that we came up with and in part this has to do because we've had a recent inquiry about a physician who doesn't necessarily want to respond on their own in their own vehicle, but does want to participate in the EMS process and for that particular person that's a physician responder dependent, and by that we mean that it is a physician who is riding on an ambulance who's going to be assigned to a crew at all times. They're always going to be with an EMT or a paramedic or some other level. The physician will not be responding without an EMS crew member with them, but may provide on-scene medical control superseding the physician on-scene protocol. The physician will respond only with the agencies that he or she is affiliated with and through which the physician has been approved to act in this capacity. So the particular agency, like GBAC, wants to engage a physician to come and ride along and that physician will then be able to give orders on the scene, but will always be with another paramedic for scene safety and what not and that's what this is referring to. For the purposes of this policy, Upstate One Physician Response Team is also considered an agency as well for the purposes. Now, the agency may revoke the privilege at any time with written notification to both the physician and Central New York EMS. The physician does not have to be a medical director of the agency, but must have a written approval from the service medical director if that physician is not the service medical director him or herself. Sir?

Cooney: I missed this before, I'm sorry, Chris. It says – I missed this before. This is Derek Cooney. So the language here is really good. There's one thing that remains to be changed up at the top where it says riding on an ambulance, assigned to a crew at all times, consisting of an EMT or higher, so if we are lumping in – if this is where we choose to put the regional field physician response credential for the Upstate Squad 1 team, the _____ then there's a problem with that language because obviously there's no ambulance and there's no EMT or otherwise crew.

Fullagar: Done. Okay. Anything else?

Cooney: They're still not assigned to the crew at all times.

Fullagar: They're going to be independent, that comes next.

Cooney: Ah, ha.

Fullagar: Pay no attention to this. This is as if you want to engage another emergency physician that rides with you regularly, this really doesn't apply to you.

Cooney: Okay, got it, now I understand.

Fullagar: it's coming. It's coming. So the requirements for this, you have to have a valid New York State license, you have to be board certified or eligible emergency physician or a physician in another specialty with significant emergency medicine or critical care or EMS experience. This is where they have to have the base station course because they're going to be giving orders like they do in the ER. We decided to leave the compliant obligation compliance with occupational health and safety with the agency itself so that has to be addressed by the agency. However, they are going to need ICS 100, 200, 700 and 800 as well, just because that essentially is part of the post-Katrina legislation and they should know about ICS and NIMS anyway. They have to have proof of malpractice which covers EMS agencies including medical direction and direct patient care. That's kind of a no-brainer. And then they also have to complete the Central New York EMS physician application and have approval by the REMAC. Any questions there? Yes, sir.

Iannolo: Would the malpractice coverage specify care in the field?

Fullagar: Yes.

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Fullagar: Medical direction and direct patient care.

Iannolo: But that could imply –

Cooney: EMS activity _____ proof of maintenance covering EMS. _____

Iannolo: That's kind of what I mean, they could present a malpractice insurance that doesn't have a modification in it for actually taking direct patient care.

In the field.

In the field.

Fullagar: Okay, done. Any other questions? All right, physician -independent . This is where the Upstate _____ so this is a physician who is authorized to respond to the EMS call. For example, in a car without another prehospital provider present. The difference here is they're going to be on their own. So they have to have more requirements than a person who will be with an EMT the whole time. So this physician may provide on-scene medical control superseding the physician on-scene protocol. The physician will respond only with the agencies that he or she is affiliated with through which the physician has been approved to act in this capacity. However, mutual aid responses are permitted. So if Dr. Landsberg goes out with Mottville and he is in Skaneateles and there's a call in Jordan and Jordan MD-2 is not in service. There's nothing that prevents them from calling Dr. Landsberg and saying, hey, can you come over and help us in Jordan. For the purposes of this policy, Upstate 1 physician response team is considered an agency. The agency may revoke this privilege at any time with written notification to the physician and Central New York EMS. If the physician is driving, ~~there~~ they must be a member of the agency that they are riding with and covered under their policy for insurance for driving. The physician doesn't have to be a medical director of the agency, but must have written approval from the service medical director if that physician is not a service medical director himself or herself. Does that make sense? Okay. The requirements are a valid New York State license, board certified or eligible in the areas that we discussed before. They also have to have the base station course. The occupational safety and health will be deferred to the agency. They have to have the ICS minimums, encouraged 300 and 400, but that's not required as a minimum, completion of an EMS fellowship or EMS subspecialty board certification or significant prehospital emergency care experience. So it is very possible for a physician to be a dependent physician for a while to gain the experience and then when sufficient experience has been gained that they can apply for this designation as well, but the purpose here is a safety issues because these docs are going to be out in the field and they have to make sure that they have experience and training to be able to operate safely in the field. Again, they have to have proof of malpractice covering EMS activities and direct patient care in the field and the service medical director approval if they're not the medical director, they have to complete the applications and have the approval. In addition, if they are driving their own [emergency] vehicle, they have to have a valid driver's license, EVOC or equivalent and proof of active membership of the agency that they are covered with and are subject to any agency policy and insurance requirements in regard to operating the emergency vehicle. Any questions with that one? Okay.

Olsson: Will these new requirements be reflected in the new applications?

Fullagar: Yes. The application is going to be a separate thing from the policy. Right now we just want to address the policy and go from there. Any questions? Yes, sir.

Cooney: One thing, excuse me for not noticing it earlier, I wonder do we need a DEA license for a BLS medical director, do you need a DEA license to order things like albuterol, Narcan, etc.? Many of those companies will ask for them even though you and I could write a prescription without a DEA number.

Fullagar: Right. I think that for the purposes of the minimum requirements, I don't think that we necessarily need to put that in there. If they have an agency that happens to be contracted with a facility, with a supplier that requires that then that's between them. But I don't believe that the State requires a DEA for noncontrolled substances. Is that correct? I have a nod from the representatives in the room. Okay, that represents the majority of the substantive changes of the policies. Now, we also went through and we cleaned up a lot of the policies and we updated them. In addition, a version of this with corrections to the grammar and the format so when we eventually entertain a motion I would request that motion carry the stipulation that we can provide the appropriate changes to grammar and text. But what we did essentially was in the previous versions of the protocols, every protocol was in the body – the previous version of the policy, every previous version of the policy was within the body of the policies which kind of made it very cumbersome. What we did was to take that out and put it an archive and in the beginning to put a reference as to where that policy went, if it is superseded by something else. So you can still reference it, but it's not going to be within the entire body. So what I'm going to do is I'm briefly going through the other changes, i.e., the new protocols for 2014 that we put up here that really don't have as much detail as the one that I just did which

had a lot of its substance. So essentially for the first one the pronouncement of death in the field may only be attained by EMT or higher, okay, and under here we changed lividity or rigor mortis, before you had to have both. And we took out this because this doesn't really exist any more. All the changes from the previous versions are highlighted in yellow. Any questions about that one? The next one, Storm/limited transports, we just expanded the authority of the regional medical director to enact this policy for emergencies other than weather conditions. So if there is some other kind of catastrophe that necessitates noncritical patients to go to a facility other than a hospital such as an urgent care this gives the regional medical director the authority to do that. _____ that we really changed there. For the next one, we changed ILS to AEMT. And this has to do with ALS providers transporting in BLS vehicles and what they can or can't do. So we just made that one change. As a quick aside, in addition to the housekeeping changes that we made here, once we're done here, we've approved all of the non-substantive changes it's going to go back to the committee and if there are any additional changes of substance we're going to bring that back in November to approve or not approve, that is the question. Again, we've changed here ILS to AEMT. We've taken out the EMT-B and EMT-D designations because they're old and then to be in service we just changed ILS to AEMT and the unit has to be appropriately stocked. So you can't have a unit in service if it's not appropriately stocked. And appropriate stocking for an ambulance agency requires a minimum on an individual who is identified and named on the schedule either in house or from home, that includes a driver and another individual that is minimally an EMT or higher. So you can't just say that we're going to scramble for a driver and hopefully one will respond and therefore, we're in service. You have to have an individual name to that if you're going to put an ambulance in service. And then they also have to report the number of rigs in service and the level of training for each rig if they have level _____ and the changes from before are just highlighted there in yellow. Okay, that's a part of the same one here. We cleaned up a little bit as far as the dispatch program. In the old protocols you might have noticed that there was about two pages' worth of criteria for what's an ALS call, what's a BLS call, what constitutes each one of these. What we've done is Susie has queried all of the dispatch agencies, including the public and private, and we've determined that they're all using EMD. So we're just going to say that they have – they have completed the emergency medical dispatch program, they can use that criteria in order to determine what level of response you have to have. And then the minimum training for call takers, we just added to the extent allowed by law because there's a certain degree of _____ that we as a REMAC don't have the authority over, but to the extent that we do have the authority as far as any medical care decisions we are going to maintain the minimum standards for the call takers and the dispatchers. All right. Any questions so far? Pretty straight forward. This has to do with corrective action. Now, as a corrective action, I would just want to say is going to be one that is probably going to be going through some additional changes over the next few months because I think that – _____ briefly, I think that there are issues that we have to deal with in regard to not only this policy but also the corollary to this policy which is the CQI manual for the region. So I think that warrants some degree of discussion and I think that that's going to change. What the purpose of these changes are essentially are just the updates and the housekeeping changes and the substantive changes to this will be ongoing. So for this essentially we just changed a couple of words here from the quality improvement committee to the quality improvement program and then we put in a reference to this CNY EMS Regional CQI Manual. These essentially are things that harken back to what we had before as far as what has to be referred to the agency. Again, this is stuff that we're going to be discussing further. That part has not really changed. We did add the caveat here because this is a more immediate issue I think and – the medication errors that only involve route or dose calculation are – we're going to make the requirement that you can consult with the agency medical director to determine if that has to go onto the region or not. Referral to the Program Agency for intake will be at the discretion of the agency medical director. The only other thing that was added was the criteria for part 800 which is listed in _____ . So this was the only thing of substance there that we added, but we're going to kind of overhaul this as well. These are the reportable things here with regard to part 800 which we added and just changed the Executive Committee to the Executive Director who will be the people who would notify as soon as required. Any questions so far about that? 1406, we changed – this has to do with the interim medical director and that they can have an interim medical director for up to 90 days. _____ 60 days and by the time they are notified and _____ get people to respond back might be a little short and in regard to credential service and medical directors if an agency selects a service medical director that's already credentialed by the REMAC, the agency will submit an updated medical director verification form to the CNY EMS and forward a copy to the Department of Health. For non-credentialed medical directors, if the

agency selects a medical director that is noncredentialed the physician will have to submit this form, essentially go through the process of the previous policy that we just went through. Yes, Dr. Cooney.

Cooney: Since we've just created a situation where we have BLS credentialed physicians and ALS credentialed physicians, do we need to stipulate that as policy, that it has to be the right, they carry the credential at that level?

Fullagar: Right, and I agree with that. I think that when we discuss this in a little more detail we probably then be making a few changes and I think that we can relate directly to the policy itself. So what I'm going to do for the time being is just add at that level and we can make the grammatical, wordsmithing changes, with the approval of the body. If there's something else other at that level, that we can come up with that sounds prettier. Because we want these to be the prettiest. Okay, so okay, the Program Agency should be contacted instead of the Program Office, again, not substantive changes. All right, so this is 1407, this is ALS for patients receiving medications from BLS providers. The ILS was changed to AEMT and we just referred to the Central New York EMS routine medical care and trauma protocol instead of listing them all in this policy here. Instead of initiating full routine ALS on the patient we changed that to reflect the changes that we previously made – or that we previously discussed at least in that there are times in which you need to initiate appropriate ALS interventions and there are many times in which you don't have to _____ . That was just agreement with what we had prior. Any questions so far? All right. 1408, this is just a verbiage change from "should be" to "may" in regard to patient refusals _____. And this policy we took out some _____ some of the levels no longer exist and update it to AEMT where necessary. This is the minimum equipment list which was updated to reflect the AEMT standards. And –

I can't remember, _____ does that include drugs on it?

Fullagar: Yes.

Did we already update it to include the narcotics or did we always do that? We haven't always because like Lafayette _____

That won't be until June of 2015.

_____

We'll have to do that at our May meeting that mandate.

Fullagar: Currently it does say for morphine sulfate EMT-CC and EMT-P _____ .

So I could –

_____

Surprenant: Because then we have the State mandate where it's going to change so – you're right, Lafayette or anybody else that doesn't have controlled substances is going to have to have it sooner versus later.

Cooney: So presumably it's not yellow on that version there, that it is already in place _____

Surprenant: If you see the asterisk next to it –

Cooney: The asterisk just says you have to have a State controlled substance, but it doesn't say you have to have to carry, that chart implies that you have to have it already. Right?

Surprenant: If you're licensed to carry it. So if someone like Lafayette hasn't gone through the process they're not licensed to carry it, but you're right that will be changing because of the SEMAC change that all ALS units will have to have controlled substances.

Cooney: Presumably you don't have to change this policy at all _____

Fullagar: We didn't make any changes other than what was in yellow and essentially what we did was to add the AEMT and take out ILS as required.

Surprenant: And actually if we look at the timing of the AEMT change, it will be done in June of 2015, that's right around the same time with controlled substances so we can take care of both of those. We'll eliminate the column for ILS and then you would actually eliminate the asterisk for the controlled substances and then it will be required for everybody. So that the timing would be good at our May meeting of 2015.

Fullagar: Okay. Electronic PCR submission to REMAC. This is a new policy which essentially reflects what some of the other regions are doing. It's not really earth shattering here. Essentially this states that the Bureau of Emergency Medical Services Policy Statement 1203 states that all the services must submit the standard New York State data to the regional program and this is a

reflection of that essentially. The policy statement states that the EMS services must receive approval from the Regional Medical Services Council, the REMSCo, and the REMAC, and the New York State Department of Health Bureau of Emergency Medical Services. All EMS systems in Central New York region who are using an electronic PCR are required to have signed a memorandum of understanding that is up to date and on file with the CNY EMS Program Agency. That is not new. We've always had that. The services shall contact the Program Agency in writing to obtain credentials to access the regional EMS bridge, and this bridge is the new thing here which just allows the agencies to dump the appropriate data into the region so that's – the bridge will facilitate that transfer of this particular data points, am I correct?

Surprenant: Yes.

Fullagar: Okay. So essentially all of the services in the region – okay, these requirements as far as _____ were taken directly from 1203. So essentially at the time of transfer of care the State states that we have to leave a document that has certain criteria in regard to the patient's demographics and vital signs and what interventions have been given at the time of transfer of care and then the electronic PCR must be completed by the end of the shift that you have treated the patient. So you can't go home essentially without completing your paperwork which is what that says. And that's just a direct reflection of 1203 from the State. EPCR system has to be in compliance with NEMSIS III which is also a State requirement and the New York State EMS Data Dictionary. So any services that are currently using a non-NEMSIS III compliant EPCR will continue to export directly in the State bridge until they are able to export until the regional EMS bridge. So all this really is is a reflection of what the State requires with the added caveat that we're going to have an electronic bridge to allow the data to be dumped directly to the region. All right, this has to do with EMS physicians which we've already covered that policy. This has to do with multiple aircraft responding to a single scene. This went to the AMS Committee and essentially what we were looking for was the update frequency which is now 123.025 if you want to write that down. And essentially the highest level of EMT or EMS physician on scene can determine if no aircraft is needed and then _____. That was changed specifically an EMT – an EMT critical care or paramedic so it's the highest level of EMT can cancel. 14 has to do with CON and this is directly from the REMSCo so this is not really anything that we need to bother with other than to know that it exists and that this meets the requirements of the REMSCo. And that my friends is it. Any questions?

Surprenant: The two policies involving CON and COT. There's a separate Policy Committee of the REMSCo and they have the CON updated one, the COT so they will do that at their September meeting to get those approved. The timing of these, they're trying to get everything done so that it doesn't have to be re-released multiple times.

Fullagar: So with that and with the blessing of Dr. Olsson, I would like to request a motion to approve the policies as written with the grammatical, formatting and non-substantive changes that need to be done.

Cooney: Just so I understand because you said that this was going to go back to the committee and then come back, so are we approving them period or are we approving them to go back to the committee?

Fullagar: We are approving approving them. These are going to be the policies that stand now, but then what we are going to be doing is going back to the committee for further discussing this and any changes that we made between now and November will come back for approval of the body.

Cooney: Gotcha.

Olsson: So if I can clarify the motion is to approve the policy statements as written and presented tonight with an understanding that there may be some verbiage changes and if those changes do occur they will be brought back at the next meeting, but everything, all the work that has been done so far we're okay with.

Fullagar: The verbiage changes and the non-substantive changes, like the grammatical changes will be done and approved by the body if so voted on, but any additional changes of substance are going to come back.

Olsson: Okay, we have a motion.

We have a seconded motion.

Olsson: A seconded motion. Any discussion? No, good. All in favor? Opposed? Done.

Fullagar: You know we talked about how this was laid out. I discussed this at first and if they were removed, the old ones, _____ . Thank you.

Olsson: I do want to thank Dr. Fullagar. For those of you who have been around over the years and have sat through, updates and policy statements, this would have been several meetings and several hours' worth of discussion and this has really allowed us to jump forward to a substantially huge degree so I appreciate everything.

Fullagar: Dr. Olsson I would also like to thank the committee because that's where _____ work was done so I appreciate that.

Olsson: I agree. We'll back up. Dr. Cooney, any words of wisdom from the REMSCo or anything regarding Air Medical.

Cooney: So just to bring everybody up to speed if you don't already know, the AMS Committee which is comprised somewhat of all three regions. It predates the separation of the regions so there's a lot of historical sort of gray area there. The history is not gray, but the authority and where that committee actually lives is a little bit gray and the reason that I mention that is not _____ excellent committee, just as a precursor to the issue at hand concerning the air medical clearinghouse. So the air medical clearinghouse which everyone in the room knows what that does, but presumably everyone knows what that does so briefly if you are a provider on the ground and you need a helicopter you key your mic, ask your 911 center for a helicopter, they make one phone call and get you a closest most appropriate air medical ambulance and that's just what we expect from on the ground aspect so that's what everyone has come to expect in the air and the reason that it has to go somewhere other than just the 911 center because the aircraft covers such a vast distance and in fact all three regions used one dispatching entity for that and that has been independently contracted by the Council out to TLC. Now each region has the right to contract and not contract that entity. So historically all three regions have contracted with one singular contractor, being TLC, and TLC has for over a decade I believe provided that air medical clearinghouse service to all the counties covered by all three regions except for I think one or two who do not participate, they do their own phone calls. That being said, the AMS Committee formulated, which again this is made up of members of all three regions, but it doesn't sit directly under the Regional Councils normal committee structure or under the REMAC's normal committee structure so it sort of is, not independently, but sort as a, I don't even know if you would call it an ad hoc committee of all three regions, it put out an RFP, a closed RFP to three potential contractors to provide continued services of life flight. They actually asked for additional things in their RFP that would make the service a little bit more robust than previous, not that it's any better or any worse, but they were just more specific about how they – what they wanted out of that contract. That being said, that RFP was sent out and it was sent to Rural Metro, to Mercy Flight Central and to – not LifeNet New York, but their parent company which is Air Methods. So the stipulated components of those were met by proposals by both of the air medical services, Rural Metro did not return a proposal and TLC was not invited to submit for those. So ultimately what happened was the AMS Committee reviewed presents from the two air medical services and everyone on the committee recused themselves except for four people because they had conflicting interests and they voted to select one of those companies to provide that service and it was a no cost, both of them were zero bid to the regions. That then had to go because it's not really a committee of each one of those REMSCos, it came as a seconded motion, but really it would have had to come from the floor as a motion, but it came as a motion to the Council – it was to come to the Council as a motion, but because it's not a standing committee it can't. It had to go through the Executive Committee because the Executive Committee, runs, supervises and oversees all contracts for the Council. And at that time the Executive Committee asked that more information be provided and including potential other alternatives other than maintenance of clearinghouse which is not a State deliverable. And what I mean by that is the Council and Program Agency have no obligation under contract with the State to _____ comes from to provide that service. However, it has inflicted some financial burden in the past when there was a dispute about how that function was applied by the contract with the agency, and in fact there was a _____ . So ultimately I believe two – our two sister regions have at least temporarily and maybe unofficially or officially, I'm not sure, because no one has advised us, signed up with that agency or at least they're using that agency now to provide their air medical clearinghouse service and that's with Air Methods out of _____ . But our Council is actually still _____ . We formed an ad hoc committee to look at it for our region and that committee is made up of one Executive Committee member who has no tie to air medical services, all five EMS coordinators and Dave Butler, representing TLC, who has agreed to continue to provide air medical clearinghouse services until a decision can be made by the Council about whether or not (a) is the Council going to pursue a contract as an agency for a clearinghouse, because there's a potential just to say, well, it's up to the 911 center and we don't

have authority over that, and therefore we shouldn't really be involved in that, or (b) provide an advisement or actually contract directly as a region _____ . The current method _____ appear to be potential options, although that conversation has not taken place so I can't really tell you _____ and ultimately they're looking to the counties to see what the counties desire from a dispatching perspective and then the Council would pursue that option either as a supporting function or again to reestablish another contractual obligation. So _____ on, on and on, but the problem is it is a lot more complicated than it appeared at the beginning. So there's been some unofficial legal advice and some other things going on so that the Council can making an appropriate decision, keeping in mind it is a fiduciary responsibility _____ .

Olsson: So in the words of Warren Darby, we're still up in the air, all right, thank you. Okay. _____ We could grab some food and be back by 6:30? We can talk and eat at the same time and –

_____

Olsson: Okay, we're going to go back on the record.

_____

I would like to formally welcome and acknowledge Dr. Kasky and Dr. Wirths sitting back in the corner there and Dr. Kasky is a new addition to the Upstate faculty as is Dr. Wirtz. She is our new EMS fellow.

(Clapping)

Olsson: And at this point – this would be a good point then, we'll talk about Dr. Wirths. We have her application as service medical director. As you know, we take applications for physicians to become medical directors and field response, etc. So she is board eligible and you will see that she is on faculty privileges at the local hospitals. She is listed with Rural Metro and Upstate's Squad 1. That will be part of her fellowship duties I'm assuming. She comes from the State of Maine, State of Pennsylvania, core instructor. She has completed the four basic listed requirements, and we've got her CV which shows residency, medical school, undergrad, and all of her credentials are listed, including the ICS courses as well as the essentials for EMS, firefighter 1 and 2, rescue, haz mat and fire employment and so I would entertain a motion for her acceptance and/or discussion or approval.

So moved to accept.

Olsson: All in favor? Okay, done, congratulations, I think. Okay, do you want to talk about Narcan?

Surprenant: Okay, as stated at the previous meetings we are now up to 21 naloxone agencies that are participating and they keep increasing so it's to see that this program is going well and we're getting a lot of participation and not only in this region, but State wide. So as Dr. Fullagar went over the policy statements on the electronic data submission, the regional bridge and as John alluded to earlier, what's occurring that's going to affect State wide, there's one vendor, EMS Charts, that's being used in over 300+ agencies throughout New York State. So back in June when we met, the directors meet with the Bureau prior to SEMAC/SEMSCo, we discussed as directors the possible impact if the litigation with this agency, with this vendor doesn't go well how that's going to affect not only this region, but multiple regions. And we felt that a proactive approach and having a plan B in place for the agencies would be beneficial, especially knowing that NEMSIS III is coming on board, coming down the road. So what we did was meet and we've also met actually three times since June with the State and also the vendor that actually does the State bridge which is Image Trend. They are developing the necessary compliance State bridge for the Bureau of EMS as well as they have products on the front end for EPCR and also fire bridge. So they also met, since they were in town, talking to Dr. Olsson and I about the regional bridge, we actually have a region to our self that had to do that and go into that, Susquehanna Region did not have – their homegrown product was not able to go to NEMSIS compliance so they actually brought in several different vendors, and looked at that and actually the vendor that they selected just happened to be Image Trend. They developed a regional bridge and what that allows is that it will allow for any NEMSIS III compliant, because it will be NEMSIS III from the start. Their new product goes live in October, and what is going to happen is any agency that's doing electronic patient care records will be exporting into the State bridge and that will be the entire PCR – the regional bridge and attachments, and what that's going to allow is just one export from the regional bridge up to the State bridge. The advantage of that is especially for the medical directors that have multiple agencies is that you have one log-in and you will be able to look at all of your agency information no matter what electronic platform they originally have. That's one advantage. The other advantage is for the hospitals, instead of faxing all of these electronic records and going to the fax machine

and if you're _____ or the patient has been moved to the floor, you're looking for the patient care record, that the hospitals would have a dashboard that they would be able to grab the PDF of the electronic record and actually insert it into their patient care record in the hospital. The other thing that we've met with is the local RHIO and this company also is working in other states to do the hospital information exchange. So this for having one regional bridge we've be able to work with the local RHIO to be able to make sure that EMS data is also linked with the hospital data, but also get some information back on the patient outcome which we haven't had before. So by us having one regional – basically regional repository of data it also allows us to look at regional trends easier, protocol development, okay, what medications are being used, and just different things that we haven't been able to do because of such a fragmented system currently. So even though this is bad for the vendor that _____ is going through it also opens up an opportunity because of the NEMSIS III coming down the road so that's – this is reasons for looking at doing and also the other thing is the region to our west which is Monroe-Livingston Region is actually rolling this out to their group on Monday as well of doing the same thing. So this is an opportunity for us to have more of a less fragmented system that currently is in place. And it's being supported by the Bureau wholeheartedly.

Morrissey: _____ one of the things that's important to note, too, is that particular system allows you to drop short chart at the ER before you leave it.

Surprenant: Correct.

Morrissey: And that's a huge advantage to people that are leaving paper and then trying to transpose over and so forth. It's still in electronic form, but it's just – it's called a _____ chart and they do that, and the other interesting piece, too, is you can tie your first responder agencies in who _____ and do things so it has some other neat things that the Southern Tier has been doing, including doing the State fair reports and so forth. So it's something that people should look at, and again, EMS Charts continues forward and there are a number of other options out there _____ .

Surprenant: We have a request from Fair Haven Village Ambulance. They would like to upgrade their fly car to ALS. They are sitting right on the county line and actually do, they are being requesting more and more _____ the paramedic or the critical care. So they asked for that upgrade. I did the inspection yesterday and they only thing that they're supposed to be getting, there are four items that needed to be put on order that's supposed to be arriving tomorrow. So my recommendation is that we approve their upgrade contingent on their controlled substances being picked up tomorrow as well as the supplies being delivered tomorrow. Once that occurs they will be able to upgrade that and that requires a vote of the REMAC.

Olsson: Any questions about the ALS fly car update? It would be to approve pending the changes that Susie mentioned getting their controlled substances, etc. Comments? All in favor? Opposed? Carried. All right, do you want to talk about Bangs?

Surprenant: Yes. So what's going to happen now with agencies looking at possibly changing from their current vendor, one of the things that we had a discussion with with the Bureau of EMS and Mike Taylor is in charge of the electronic patient care system is when agencies, the policy requires REMAC approval, REMSCo approval as well as State approval when an agency goes electronic, but that also means when they switch vendors that approval has to be in place. So we're going to have to do that with almost 40 agencies if – in this region that probably possibly 25, 30 that are going to want us to switch. And the timing of our quarterly meetings makes it hard if the switch is occurring so what we've done in the past when we knew an agency – or a vendor had a web based application like EMS Charts, we know that it's one central repository of data, the interface has been tested, it uploads to the State bridge. We actually as a REMAC and we did the same thing with _____ okay, anybody that's using this product, they have REMAC and then REMSCo approval and as long as there's a signed MOU and they are compliant with the statements. Since we are going to be going through this, I would like to do the same thing, enlist the current vendors that are in place and to continue that because we have some vendors that aren't NEMSIS III compliant, but the new policy statement allows for that transition the State hasn't put a deadline on NEMSIS III yet. They prefer us not to do that. There may be depending on how active the vendors are switching. In the past when we went to NEMSIS II compliancy eventually there was a deadline put out because some vendors were a little bit quicker and some were a little bit slower in the transition. It's important also that there's no loss of information and that is one of the things that we asked with Image Trend if there's a repository, one of the big things that the agencies worry about is what happens to their historical data and attachments. The vendors assured us that anybody that is switching that that will come over and that that will happen, and they're actually doing a very

nice arrangement for agencies to make that possible because that was a big concern not only for the regions and the State, but also the agencies of losing that historical data because we've had agencies electronic for almost six years now, some very large agencies _____ . So the ones that are being currently used is Zoll and that is NEMSIS II right now, but they are in the process of beginning the pretesting and working with those agencies to find out from the vendor when that's going to occur so I would recommend we continue to recommend that. EMS Charts is in the region currently, but the last time I knew they were not accepting any new clients and also ESO is, but only on a BLS agency. So we're going to have Bangs that's going to be the first one to request an ALS because that's going to be total different testing that we're going to have to do with their interface. For Image Trend my recommendation is that as long as agencies are going to the regional bridge and the structure for that that we can happen. There is the ability with that software application to actually go separate, but the key will be to comply with the State policy, our policy and that information is coming to the central repository and then our ability to get it to the State repository. So my recommendation is also to do an approval for that so that by the time we hit our November meeting I can say these are the agencies that we've approved. We'll ask the same thing of the REMSCo. Dr. Cooney is the acting president right now. For anybody that didn't know, Jim Jones had to resign because he took another position. So we're going to ask the same thing because my concern is agencies are going to have to move quickly this fall and I don't want the timing of our meetings to prevent that from happening because there are some agencies that are very concerned with making this transition happen and also because they have to train a lot of providers to do this.

Cooney: Just a point of information I suppose, _____ either you or Ray _____ definitive answer, as you may remember this came up in the Council as well, is there a regulatory requirement to bring every single instance to all three or can we do as _____ simply just say these are the ones that are approved, if you're going to give us an MOU and _____ you're done, and we don't have to bring it to a vote _____. Can we do that _____

_____

Cooney: Can that be done or is that written somewhere in black and white that we can't do that?

Morrissey: Let me say this. The last time I looked at the approval process was when we were in the midst of a major case with an agency up north that has some issues with PCRs. And the answer that I got back was it had to be approved individually through this process. They did not want it – they wanted it, boom. It had to go through the process of what you traditionally followed. Mike Taylor is well aware of the meetings that have been going on and we acknowledge that this is the thing that's happening State wide. I certainly will make a phone call tomorrow to get the answer to allow that to occur and I'm relatively sure that the Department will not oppose that.

Thielke: Yes, I was just going to say that given current situation I think that the Department would be good because this is a State wide problem.

Morrissey: Now, I also know that part of how that approval process that came out of the subcommittee, SEMAC, if you remember when we originally started this, it created that process so I don't know how much latitude Lee has. And that's the best that I can give you. Now, certainly maybe one of the things that we could do here is to electronically poll the sitting REMAC folks to get approval electronically, that's one way to do that to meet the requirement, okay.

_____

There's no reason we can't _____

Morrissey: Not a public record, but if you introduce that we did that and here are the results in the next meeting.

Surprenant: Because Executive Order #3 requires us to be webcast.

Morrissey: I understand that, but when you can put minutes in between _____ under new business. Again, I don't want to tell you to go ahead and do this and then have that SEMAC – which originally created the approval process had bound Lee that she can't do – allows a lot of latitude. That's my crisis. The Department issue, I think we can absolutely say, but this is SEMAC-based process of how this was supposed to happen.

Surprenant: Because the process – the nice thing with the approval process it prevents vendors from sliding under the radar or agencies and – the nice thing because we've had this process in place for six years we have a clearer process in place that's worked and we can show that to the Bureau and the nice thing is we've been able to show that all vendors that are coming on board with

the agencies that they're tested. I know exactly because I tested _____ in the State bridge, even before they go live we know whether they're going to be able to import data to the data repository.

Cooney: I would never suggest that we do anything that would leap frog the tech component, but as you heard at the Regional Council, nobody at the Regional Council was interested at all in preventing any agency from going electronic. In fact, there are many physician oversight reasons that would advocate that _____ financial component so that's probably not a good idea at this point. So maybe what I'm asking is that we can look into that, but also maybe from the Council's perspective I probably will pose the question, but maybe we can pose this question to you, Dan, would you be comfortable taking that to the State? Because the SEMAC is saying, hey, this works, can we get rid of these components? The State is still going to approve each one of these independently.

Surprenant: Not get rid of it.

Cooney: But we need to just be looking at the technology and the interface and not be talking about who can – what agency might be eligible for utilization the state of the art standard of care which is electronic PCRs.

Olsson: Let me just, regional medical directors have a certain degree of latitude of doing stuff. So I would propose that between now and the next meeting, Susie and I would review the changes for electronic PCR vendors. We already know who the vendors are, there's only three or four, and the agencies and make sure their paperwork is up to snuff, give them the verbal go-ahead and at the next REMAC meeting present a list of the agencies and the changes and then the five physicians that show up can say yes and that way we've done the approval process, it's approved by the REMAC, everybody's happy.

Morrissey: I think Dan makes an excellent point. _____ have latitude –

Olsson: And the SEMAC is going to have to do their own thing.

Morrissey: Right, and I think that makes a lot of sense. I will make the phone calls. I'm going to have trouble getting ahold of staff tomorrow, but I will on Monday and certainly – I don't think Lee's going to have a heartburn with that, but I haven't talked to her about it so I don't want to promise it's okay.

Olsson: Like I say, there are times when according to Mr. _____ there is unilateral abilities to do stuff and so I'm going to declare that this is one of those times. I hope you're happy.

Surprenant: There are very good points. I think the regional piece was in there because it allows – like for this region we said NEMSIS right now we wanted the gold standard and the reason for that is because we've been electronic for now six years with some of our agencies. We already went from an old system to the new data repository, but by keeping that standard it allowed our agencies to make that transition and now go through the turmoil of okay, now, I've got to pick another product. So by having certain standards at the regional level it's going to allow our agencies to transition easier and the same thing with this and I think that's probably why a lot of regions are looking at the regional bridge. It was nice that Susquehanna paved the way for some of those because of their homegrown product having issues, but that some of the things that we're looking at is long term how can these agencies sustain in the current products and not, you know, enter a contract because the vendors say, oh, I've got this, and vendors have done that. They want to sell and that's their business, and because we've had a good communication with the State we've been able to say, no, they are what they say they are so that's one of the things of having both a regional and State process, but I think Dr. Olsson makes a very good suggestion. So I do have one request already so we can do this because this is an official request from Bangs Ambulance who is currently using EMS Charts, is one of our longest EMS Chart agencies, is that they would like to transition to ESO Solutions and I would bring this forth between the REMSCo as well, they'll be signing a new MOU and then we'll make sure that this is able to export to the bridge as needed. So we need an approval from this level for them to train, to transition to ESO for an ALS ambulance service.

Olsson: Any discussion? Assuming of course that the interface is all working and the MOU has been signed.

Yep.

Fullagar: And ESO is on the approved list.

Surprenant: We only had one BLS, we've never tested ALS, but this is a great agency to test that out.

Olsson: It does have to be tested and if it meets the test results, then – all in favor? Opposed? Carried. I don't know anything about that.

Okay.

_____

Surprenant: So we have an existing grant that Excellus granted to Upstate Medical University for _____ . We've been asked by Jay Scott to provide agency specific information. The only problem is to help with their response to Excellus on patient outcome and how much it has been used, we can't grant that request because one of the specific things in the Program Agency contract is I can only release agency specific information to an agency, to the REMAC for internal quality assurance purposes or to agency medical director. It is not able to be to a third party. So Jay originally asked to be on the agenda to see if we could get REMAC approval. Mike Taylor has told me that REMAC doesn't have the statutory authority either to release agency specific. A data use agreement would have to exist between the agency and the third party and the agency whose data it is would have to release that information. If an agency asks me for information, I can give it to the appropriate manager or owner of that company, but I cannot, otherwise I jeopardize our contract with the State.

Cooney: So they funded it, is that what's happening? So now they specifically are asking, we gave modems to A, B and C services and we want to know if they're using them, is that the query?

Surprenant: The question to Dr. Jorolemon and I were, what agencies have transmitted EKGs, and he gave us a list of 12 agencies and said, how many uses of their modems have been able to, you know, specific information and we can't. I don't want to – it was great to get that amount of money and to get more modems, but we don't have the authority to do it.

Cooney: So if this, you know, if the insurance companies make arrangements _____ negotiations with EMS agencies on a frequent and regular basis, and the design of that information is for them to approve their reimbursement _____ agencies, then presumably they should just ask the EMS agency for that information.

Right.

Cooney: And you have the right to give it to them so perhaps is that a simple enough answer?

The agency _____

_____

Cooney: Ask the agency.

_____

Olsson: Okay, any new business or old business from any of people still awake? Okay, with that, I'll accept a motion to adjourn. Okay, approved. Most of you we will see, if not all of you, we will see you back November 13th. We are going to go into Executive Session so the physicians and executive staff are welcome to stay. All others we bid a fond farewell.

Respectfully submitted,

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CNYEMS