All right, I'd like to welcome everyone to the first meeting of the calendar year. Tornstrom promised me that MLREMS would be done on time and he's promised me truly that it will happen next meeting. Agendas are floating around. Yes, it says 2013. The office will realize that it's 2014 soon, but the date is correct. The time is sort of correct and the agenda is definitely correct. All right, agenda review, anything to be added to the agenda that we missed? Seeing nothing we will continue on. Minutes, this is our first meeting since November, I guess. We'll entertain a motion to approve the minutes from November.

So moved.

Breese. A second? Dr. Thompson. All those in favor? Opposed? Abstentions? Dr. Katsetos abstains, otherwise it passes unanimously. Correspondence and announcements. I'm going to send them around. Of note, there's one from Mr. Philippy here that he is now Rural Metro's clinical manager and the role of ALS chief for the agency replacing Brian _____ who has gone to Tennessee.

_____

Snow and cold. So that's coming around as well a bunch of New York actions and a summary from Dr. Cushman in terms of major accomplishments for 2013. I believe this is close to almost the same packet that went around for MLREMS for those people that were here for MLREMS. Dr. Cushman, Medical Director's report.

As you – so we just distributed on behalf of the Program Agency to both MLREMS and REMAC, some of our accomplishments of the year. That was distributed electronically. I will not read through it entirely, but we certainly had a pretty productive 2013 and hope to exceed that which we accomplished last year. In terms of things going on in the office and this also kind of runs the gamut of various different subcommittees is we finished the smoke inhalation of cyanide training, that has been delivered to a number of agencies around the county. There are some delivering the "train the trainer" and if any other agency needs or want that training, just contact my office _____ providers in my office will be happy to come out and do that. Everyone did get the advisory regarding the ceasing of therapy of hypothermia, and we are currently not cooling any one. There will be in your email likely within the next couple of weeks a total artificial heart protocol for review and I'll have that for action at our March meeting. The first total artificial heart patient is being discharged from Strong probably tomorrow to the Gates district. They have receiving training updates and so forth. We are working with Bill Holloman from Strong to update our _____ to total artificial heart training as well as this protocol which I will bring to SEMAC for approval as well. The 2014 protocols will be released with the go live of the new MLREMS website, ideally right around the first week of February. I will make sure that all of the area EDs get a new copy of those protocols with _____ changes so that you can make your docs aware and were updated _____ . In the end as far as the physicians are concerned, not much changes. There is some slight increase in the amount of controlled substances that can be delivered on standing order so perhaps a few less phone calls. There is change from dopamine to norepi which is probably the most important change in there to get out to your fellow docs and then also some updates to advanced directives, determination of death, termination of resuscitation. So once that goes live I'll make sure that something gets out to all the EDs so that you can hopefully get that information out to your docs. Speaking of advanced directives, determination of death and termination of resuscitation, we put together

a training module for that. That has been distributed to all the regional medical directors, all the medical directors of all the agencies in the region strongly encouraging that they deliver that training to their agencies in the next few months. The norepi training, that is in the final stages of editing and will be released at the same time hopefully as the web site and our illustrious pharmacy chair is working on getting that changed over to _____ pharmacy replacement system. I have sent out all the information to all of the area agencies regarding the provision of ketamine. As you will recall, we approved three protocols, updating the RSI protocol to allow ketamine as an alternative induction agent to etomidate, allowing ketamine to be used in case of excited delirium as well as an alternative to ketamine and using ketamine for facilitated extrication _____ all of which were approved at the State level. We have put together a training for that which has been distributed to the agencies so that they can send that to the State to get approved to carry ketamine and then I will be delivering that training to all of the RSI providers _____ that will be allowed to administer it so that's out there as well.

Is that going to IM and IV?

That's correct. Both IM and IV routes. And then what else? Oh, some continuing collaborative protocol discussion. As we have discussed before, a number of other regions are on a common set of protocols. Those are undergoing revision this year. We have playing an active part of that. The Protocol and Policy Committee spent at least two if not three meetings working on that and providing edits and updates to the collaborative protocol groups so we will have a lot of input on that and my goal is that we hopefully will be able to come on board with that when the new update is released which is tentatively right around January of 2015. I'm really hoping that our neighbors on both sides east and west will be doing the same which will be wonderful things for our providers that straddle those regions because they will be on one set of protocols. So that is our reasonable goal. Also, we continue to have conversations regarding the RSI program and will be to a competency based system from our current system. There will likely be some action items for the REMAC at our March meeting as we make modifications to that as well. So needless to say, the office has been awfully busy and I know _____ later on. It's just easier this way. Questions for me?

Okay, Dr. Cushman. Ben, Program Manager's report.

Between everything that Jeremy said and the annual report that's coming around in correspondence we're good to go, sir.

Council.

I'm going to flip out of order because it wasn't my fault that Council went over so I'm going to put up on the screen the reason why and this is actually from the State meetings. _____ was able to be there to rule out injury and he is not here tonight. The basic premise is two things of pretty major significance from the Department of Health level is that Article XXX changes will not – are not expected to be included in the Executive Governor's budget. For those that aren't familiar with that, that proposed to change the makeup of REMAC and Councils and that's really to combine them into 10 where we currently have 17. Those changes are not occurring so this next year it is important that we just continue business as usual. To reaffirm what Dr. Cushman's push is to look at collaborative protocols that would

supersede really any changes in the structure so we're on line with that. The other issue is basically this, this letter will be coming around. For those that are agency medical directors, this could be pretty significant. Following this letter will be a call to action, we'll be asking all of the members of REMAC, Council, etc. to participate in this. The bottom line is the Comptroller's Office did not pay contracts for the PDF which is the testing service. After April 1st, there are no certified exams for EMS providers. We believe that may be resolved, but most likely there will be some sort of a gap because even if they resolve it today we're not sure there's enough time for them to execute a new contract, write new exams and administer them. The long term potential as you can imagine is they come to no agreement and they have to re-RFP and find a new contractor to write, manage and administer written exams. So we potentially have a pretty significant issue in front of us. This is a Comptroller's Office issue first and foremost. The Bureau of EMS and the Department of Health clearly have some responsibility. It seems like they kind of let us take care of that so the Council has endorsed, I wrote a letter because I do not believe that it is fair to any of our current providers of all the classes that they wait until the last second to find out if they're not going to be eligible to test. So preemptively we are sending out this letter to allow our instructors of current classes to have something to say to their students about not being able to take the certified exam at the end of their EMT course in the next few months. Coupled with that, the Training and Ed Committee at the Council level is already starting to brain storm what we might have to do in several arenas. Number one, if a student is enrolled in a current class and can't test, how do we re-get them to the point of taking a certified exam at some point down the road. There is no additional funding for that. There is no mechanism to get an instructor in front of a group of people after the class is over with. So we'll talk about that. Recertification, currently, for those people that are required to take a written exam, as long as their card expires beyond their scheduled test date, under the State Administrative Procedures Act they will remain certified until such time as they take a test. Anybody who expires prior to their scheduled written exam will not be certified. For some people that's a bad mistake on their part, but as a matter of a couple of weeks it could now be months, obviously they are ineligible to work at their job and other things. So there could be some issues with that. And then certainly the aftermath of however long this takes of how we catch up so the two things that really are coming away, we just wanted you to know, especially those that are agency medical directors because you may start getting, what are we going to do, what are we going to do. Unfortunately there really isn't a good answer. The Comptroller's Office has to resolve the billing issue and then enter into contract negotiations and then the Bureau is going to have to figure out how they manage whatever happens after that. We're going to circulate this letter tomorrow so that again I think the student is the one that loses the most. If you think it's unfair, I think it's unfair, the Council reaffirm that they don't know that fairly soon. Even if it's resolved I think it's more prudent for them to know that there's a potential. Number two, is the Council asked that we draft a call to action letter to call for letters to the Comptroller's Office, to our elected assemblymen, senators, whatever. You know, the ramifications of this is, you know, this is EMG. The fact that they aren't paying our bills kind of sends a message. So we will work on the wording of that, share it and kind of again similar to what we asked for a year ago that we didn't have to do, is we asked you to again support us when we weren't being paid at the regional level for our requirement – statutory required operations. So you can imagine it took up some of the meeting. I'm a scapegoat. So I apologize for your starting late. Any questions? I know it's hard to see. It's just up on the screen. There are some revisions to this particular draft. That's why we put it on the screen. We had it in print and we modified it. This will circulate. We can certainly include the REMAC group so that you as physicians and others know about what's going on and not in the dark as well. So any questions on this particular issue or item? All right,

Council. Council business, a couple of things. We ended up last year due to the amazing efficiency of Dr. Cushman, Dr. Shah and their staff in the Division of Prehospital Care with a surplus of funds available for utilization before the end of our fiscal year which will be make decisions by March. We could be in the vicinity of a little bit more than $20,000 available for projects. One of the things that we're asking for _____ ideas on what would be appropriate. Certainly, physicians, if you have some ideas on education, maybe in regards to some of the things that Dr. Cushman's office has been doing, we are welcome to some input. In particular, you know, to make sure that we provide education for our folks, just so something you think would be helpful, send Dr. Cushman an email so he can digest that and figure out how we're going to spend that money. Number 2, it is time again for EMS awards. The information went out. We're going to ask that it be sent out again so physicians of excellence, your nurses of excellence in ERs, certainly if there are any EMS providers that you think need to be recognized from the physician level, we ask that you complete those and share those. EMS Week, we will be replicating the event last year. It is scheduled for May 18th, which is the first Sunday of EMS Week. Last year we asked for donations or financial support from the hospitals. We did get some. Our committee has not met to decide whether or not we're going to ask for that again based on maybe the availability on our finances, but certainly this year we want to again mimic what was last year which is supporting ASOPs call for educational activities. Last year if you remember they had identified stroke awareness and immobilization as their topics for EMS Week. They have not yet released this year's focus topics, but last year we had both Rochester General Hospital and the University Strong Memorial Hospital participate during the day's activities to provide educational opportunities for our EMS providers which they really liked, and of course RGH nurses beat everybody in the skills competitions. I guess that's the way they _____ . It is call to action. So any ED teams that want to come and show off Rochester General their amazing efficiency in skill, I put that out there, so. But we'll bring more information, but I wanted to put that out on the radar, that's May 18th which is the kickoff date so any ideas on that. Other than that the only other real issue was the strategic planning for the Executive Group of the Council to ensure that all of our activities relate back to our statutory and Article XXX requirements and I think we'll do real well with that. The website is a tool that we're looking at to kind of make sure that we continue on with the efficiencies that the office has put forth and ask that, you know, as physicians if there are things that you think would be facilitated by the website that you get _____. The end idea is that our Council website should be a source for anybody in our community or EMS realm to get the information they need, whatever it is. So I challenged our committee chairs to look at process mapping and – for example, if I sit down at my computer and go to MLREM.org to sign up for an ALS class, I can complete that at one place so in that process it would mean that all the available ACLS classes are there for me to see, that I can click through and get to the one that I want to attend and register for it. It's a pretty big understanding that requires a lot of preloading on that end, but our web company assures us that is exactly what they can do and what we want. So what we're asking for you is as a physician what is it that you would go to the website and want and can we build that process so that when one sitting can provide you with – whether it's protocols, whether it's the most updated education offered by Dr. Cushman's group, whether it's a listing of all the agencies in our area. Those kind of things we'd love to see that input as we start to build the infrastructure _____ . That's it.

Questions for Mark? All right, thank you for the Council as well as the State reporting. Ben, State actions?

State actions, there are three of them. It looks like everybody got them already. Philip Lamonda, Rome, New York, Jasper Volunteer Ambulance, Jasper, New York, Melbourne Jones, Freeport, New York.

Thank you. All right, as we talk about here regularly, the subcommittees are really where all the business occurs where everything gets done. If you noticed when we sent around the sign-in sheet, we listed – we asked people to fill in what committees they may be on. Part of that is we're going to keep that coming around so we can see what committees people are on and also committee chairs can see who's not on a committee and ask you to join them. What we noticed with both the MLREMS and within REMAC it is often it ends up being the same people doing a lot of work. One thing that would really benefit from in REMAC, is that people not on REMAC have actually been very active on many of the committees and one of our goals into this year is to get everyone on REMAC involved on committees. It is particularly important on the physicians' side because often we need physician involvement on a number of the committees in the content area. So think about the committee you particularly want to be on, the committee you want to be involved with, either let Ben know or come back to the sign-in sheet and put a little checkmark there and you'll get on the committee. Actually QA is the only one that's limited by application. Julie, ALS subcommittee.

Everybody should have received an email, sent it out twice now, the credentialing of paramedic providers. I did not receive any feedback on this.

Only a couple of typographical things that have been corrected.

This was approved by the ALS chiefs at the September ALS Committee meeting and is coming to this body for approval. It's been out twice now. It was actually sent out –

_____

Motion to approve.

Breese, looking for a second. Dr. Rueckmann. Discussion? Comments?

I've had no feedback from anybody out after the second –

Does anybody have comments in particular regarding this?

_____

2-1/2 years.

Not hearing any other comments, questions. All those in favor? Opposed? Abstentions? Unanimous, it's approved. Now you can go implement it.

_____

Actually we meet after this and will be working on implementation and continue to work with the RSI Committee _____ as well as the _____ .

Okay, any questions for Julie? Mr. Bill, Pharmacy.

No meeting was held, however, I have been in touch with the hospital pharmacies to begin stocking of norepi. Highland has already removed the dopamine out of their Pixis and _____

Okay, any significant shortages or anything like that _____

Salt water.

_____

Saline in any shape, form or fashion is still being rationed.

Etomidate is being rationed.

_____

Again, we're working on that process to _____

Okay, any questions for Mr. Bill?

I found a few sources of supply _____

_____

All right, great, thank you. Dr. Cushman, Protocol and Policy.

Protocol and Policy, a lot of what I mentioned in the Medical Director report is execution of the work of Protocol and Policy. As I mentioned, the total artificial heart protocol, both they and you will get essentially simultaneously the detailed protocol in the next short time and any other collaborative protocol discussions, protocol policy will be closely involved with. One item that came up during SEMAC and I wanted to make sure that this group is kind on the same place, there was a recent _____ and ACS Committee on trauma physician statement that was softer than most of us would like, but on the use of back boards, in that they can relate that they really don't need to be used for the vast majority of our patients as they commonly provide more discomfort than benefit. During the SEMAC meeting I essentially inquired to make sure that members of SEMAC all have similar ideological positions in terms of decreasing our use of back boards, particularly in the elderly, falls, things that are probably not in their best interest. At this point there is no specific protocol, but there are some models around the country. Connecticut is just rolling out one. There are some programs out west that are seeing significant decrease in use of backboards without _____ as a result. I just want to affirm with the docs that this is a

direction that we all want to go in. I'm not asking for any actions. I don't have anything to put in front of you, but _____

I think we just have to be very clear on how those models are going to be because _____ resistance _____

I think you hit it exactly where it needs to be, is that any program that we do we really have to make sure that there's very strong and solid education on receiving hospital's end of this is why this is and making sure that the patient transfers from the cot which is a fantastic immobilization device to the gurney and what not so as we move forward with that, I'm certainly going to want some of your input in terms of how to get that message out and how we can best formulate that for _____ physicians and staff. I have a feeling it will be pretty well received by EMS provided it as _____ possible _____ should not be placed. I think it's pretty obvious that with a major trauma they should probably go on a backboard. The minor trauma, it's pretty easy, it's the stuff in the middle I'm not sure, but more so on the receiving end _____ staff is very happy with the patient that was not totally immobilized _____ .

Is there anything as _____ keep somebody off the backboard to begin with?

_____

I was at the _____ meeting last week and, San Francisco EMS medical director, they implemented a protocol which has been picked up by Kansas and a bunch of other places now. They saw about a 60% decrease in backboarding without _____ their own QA _____ . He said their paper is about to be published. That basically had no significant bad outcomes. It's not quite as easy as some of the other stuff _____ outcomes. I think that he was feeling after it was implemented there _____ that it was generally a good thing the way they did it.

I think that one of the challenges that we all have is that we have no idea what the denominator is. All we know are the people that are backboarded. We have no idea how many people that very appropriately or maybe inappropriately were not having some sort of immobilization in the field. So it's really – it's difficult if not impossible to really figure out who, you know, who benefits and who doesn't because there's no real way to tell objectively from documentation, for example, should they have been immobilized _____

I'm hearing we're all kind of thumbs up, it's definitely a venue and like I said hopefully over the next couple of months we'll be working on that and then I'll _____ terms of a protocol, as well as in terms of some ideas of how to get some of education component to our _____

And the providers are aware, too _____

Anything else?

No.

Anything for Dr. Cushman? Excellent, thank you. QA subcommittee. A couple of things ongoing, we had our first meeting of the year already this year and in discussions there we are continuing our focus sentinel event reporting, the just culture program and trying to think of ways to roll it out, even beyond the _____ regional QA and we're continuing kind of our emphasis on that only dealing with potential hazards of adverse events, but also in terms of the positives and when we get commendations, which we got first one this already year, trying to push that out to the agency with the providers involved. So I guess the point I would make is as physicians, the hospitals, the docs, etc., if you get positives, please send that to the QA Committee, also, so that we can send it out to that agency/those providers to give them the feedback. The other discussion that we had at the meeting was, there was an interest of trying to think through how we can formalize followup to – about patients to providers given that that's felt to be a really strong educational tool, when you actually know what has happened to a patient. So we'll see where it goes. Those are going to be the items on the docket for this year and the committee will continue to work through that. Any questions? Okay. Mr. Breese, RTAC.

No RTAC meeting, no report.

Okay, Medical Director subcommittee, we need to get a meeting on the books which we will work on for the first quarter of this year. Any old business? I did not have any. In terms of new business, I was going to give a couple of things I brought out of the _____ meeting. There was actually a real emphasis on pediatrics and pediatric EMS this year. I'm not sure if that is just how the program committee cycled.

_____

They've trying to push it down.

_____

It was actually really nice. I don't think there was anything really earth shattering that occurred there. I think that the thing I took home from it was that given Dr. Murray's involvement, given Dr. _____ involvement before and others we've done fairly well in this region in terms of having, you know, pediatric _____ specialty involvement. I mean one of the talks was about how – go try to find one. I think a lot of the regions are trying to get to the point that we're at in terms of peds involvement. From the _____ side, there wasn't anything earth shattering. The one thing that was interesting from the usual vendors that they had out there was – it was amazing how the vendors that are not doing their research, there are things that studies have proven not to be valuable including prehospital therapy hypothermia. They were being aggressively marketed. I did not have enough energy to go and try to confront them and see what their response would be so I elected not to, but I think that was a good take-home message really that a number of us talked about that, you know, you have to be really careful when you see, you know, the ad for – you can cool people in the field, you can use the ITD, you can use this, that and the other thing when studies have shown that there is really minimal or no value to those devices. There is a big push, more on the peds side, on clinical guidelines to help with EMS in trying to come up with the research, come up with what the guidelines should look like and then actually putting together

some even training around. There are a couple of grants that come out of the Federal government that have gone to, ironically, the only other Manish Shah in EMS that I know of. Yes, it would be Manish I. Shah as opposed to me, who is actually at Baylor Texas Children's and that is what his real focus is.

Broadly or specifically.

It's broadly. I mean they are just trying to choose various topics. There's a respiratory, prehospital emergency care, supplement, there's a couple of items around pain management and stuff like that. But they're really to set up some guidelines such that people writing the protocols can actually fall back to those guidelines to really –

Again, going back to the point, there's not that many peds EMS people there, so if they can distribute, it's a good way of doing things _____

So if you'd like to talk to that Manish Shah, I can give you his email address because I get his stuff regularly. They actually had me supposedly introducing this major speaker there and I'm thinking you want the other guy. They wanted the other guy. That's really all I came home with out of that meeting. The next year's meeting is in New Orleans. This year it was in Tucson. It was a little warm. Any questions for me?

A couple of things that I just thought of. One is peds topics. FDNY is actually doing a trial as part of a study in terms of oral steroids for asthma exacerbations so it will be interesting to see what comes out of that _____ thousands and thousands of cases a month that they did so that should be interesting. One of the things that I mentioned at the Council is that at Vital Signs, which is the New York State EMS Conference is here in Rochester this year in October and the Bureau unfortunately for me knows where I live and so they have asked me to help out and I will. They would really like to freshen up their program with some more hands-on things and some other things now _____ We'll see if that actually happens or not, but nevertheless if you have ideas or – I'd love to try to show off our system, both in terms of providers and resources _____ hospitals _____ physicians involved in _____ or other things. There will be more to come, but if you have just a phenomenal idea to try to do a Vital Signs let me know and I'll _____ . The other thing that I wanted to bring up because I'm involved with it at my institution and I'm Mike is at yours and Bruce, probably yourself at Unity in terms of door-to-balloon times, and Tim directly at Highland, in that in the Mission Lifeline program which is sponsored by the American Heart Association is recognition and will soon be CMS reimbursement dollars for institutions and meeting more balloon time measures and quality measures in terms of that and EMS is finally getting the attention that is due because all of these times start with first medical contact. That first medical contact is a BLS/first responder on the scene, it's not a paramedic. And so what is the time to 12 lead time, what is your total scene time, what is your transport time, all of that stuff is tracked and involved. I'm working with Strong and with my David _____ from my office to identify some best practices that we can get out to all agencies in terms of these are really the goals that you should be targeted and then also identifying some structures with which we can get more real time outcomes based data, quality assurance data on our DTB times at the agency level so you can look back and say, wow, we're on the scene for 25 minutes and that kind of killed us because it was 92 minutes door to cath. _____ rather than _____ more to come on that. I think that if you are interested let me know

off line and I can get you in touch with _____ regional members or sit down with me and kind of talk about that. We're working on putting together a best practices guide for agencies to that and it will be particularly important for those of as medical directors to contract _____ at your EMS agencies. There is also a Mission Lifeline recognition award so the Mission Lifeline _____ to the institution which of course they want. There are now EMS awards as well for EMS agencies essentially achieving in this system really two performance measures. One is EKG for nontraumatic chest pain in individuals greater than 35, greater than 75% _____ at least our preliminary data suggests that we kick butt with that measure and then door to _____ first medical contact _____ of greater – less than 90%, 75%, which I think a lot of systems do so I'm working with _____ to figure out a system that we can use that we can use it for all agencies. So trying to piggybacking about what Dr. Shah has mentioned in terms of trying to connect hospital outcomes, that's one of them. It's not too long before the Mission Lifeline's stroke initiative comes out or it will be the same exact _____ .

_____

All right, anything else for agenda today?

_____

Motion to adjourn from Mr. Bove. Second? Mr. Breese