

REMAC111604a.txt

NEW YORK STATE
REGIONAL EMERGENCY MEDICAL
ADVISORY COMMITTEE

NOVEMBER 16th, 2004
5:00 p.m.

* * * * *

Midstate EMS REMAC of Oneida,
Madison and Herkimer Counties. Inc.
1750 Genesee Street
Utica, New York 13502

□

2

1 MEMBERS PRESENT:

Page 1

- 2 John DeTraglia, M.D.
- 3 Bonnie Grossman, M.D.
- 4 Michael Kowalski, M.D.
- 5 John Rubin, M.D.
- 6 Stanley Lonchek
- 7 Vincent Faraone
- 8 Robert Sturdevant
- 9 W. Joseph Taylor
- 10 Gregory Wright
- 11 Dan Broedel
- 12 Peg Failing
- 13 Alycia Schenk
- 14 Mark Wilson
- 15 Chris Coniquliaro
- 16 Kathy O'Rourke
- 17 Bill Stubba
- 18 Ross Hoham
- 19
- 20
- 21
- 22
- 23

□

3

- 1
- 2
- 3
- 4

A G E N D A

1. Call to Order 4

8 minutes?

9 (WHEREUPON, there was no response.)

10 DR. DETRAGLIA: Minutes were mailed.

11 Any additions or corrections?

12 (WHEREUPON, there was no response.)

13 DR. DETRAGLIA: I didn't see any.

14 Guest speakers or presentations?

15 (WHEREUPON, there was no response.)

16 DR. DETRAGLIA: Mr. Hoham?

17 MR. HOHAM: No.

18 DR. DETRAGLIA: Okay. No guest

19 speakers. CQI Report, Mark?

20 MR. WILSON: A few statistics that

21 are out there on the CQI Report. We're no longer

22 doing the patient refusal study. That study has been

23 ended. We have had an increase if we look back on

□

5

1 the study that we did before. We have increased our

2 patient care and administration. Albuterol we're

3 still doing. We have initiated the stroke study as

4 of October 1st. I'm beginning to receive data on

5 that. Gone regional and presented BLS and trauma

6 protocol roll outs along with Dan and Dr. DeTraglia.

7 We introduced the stroke protocol also along with

8 that roll out. The statistics are growing as for

9 ambulances and -- we're receiving more and more

10 patients. We're up to 254 patients as of last month

11 alone. For the year to date we're at 11,000 plus
12 patients than where we were last year. There is
13 definite growth. On CQI, I've gone back and done a
14 lot of research and digging up some old records and
15 papers. I believe that everybody has gotten a CQI
16 book manual. That would be the one with red star of
17 life on it. I've gone back and changed some stuff
18 and updated it to what is appropriate to us. I've
19 done some research in to other regions and what they
20 do and how they proceed. We basically just wanted to
21 bring it up to 2004/2005 in the CQI process. Did
22 everybody get a sheet like this (indicating)?

23 (WHEREUPON, all Members responded in

□

6

1 the negative.)

2 MR. WILSON: It's really not
3 readable. If I had a better copier, it would
4 probably come out a whole lot better.

5 DR. DETRAGLIA: Sorry. Who's on the
6 budget committee?

7 (WHEREUPON, all Members responded with
8 laughter.)

9 MR. WILSON: If you want, you can
10 pass this down. You can kind of get the idea from
11 it. Basically we want to bring everybody up to speed
12 on how the CQI process works within our region. We
13 want to bring the doctors in, the providers in with

14 how the system goes. So when -- if somebody turns in
15 a case that they would like to review, we want to
16 have a definitive black and white path and this is
17 how we do it every time. We don't want, "well, this
18 is how we did it this time." And the next time we
19 did it some other way. We want to have a black and
20 white definitive plan of action on how we respond to
21 a quality insurance review. It is somewhat detailed
22 as per agency specific in the booklet itself to where
23 they can handle it internally. It's recommended

□

7

1 handling it internally and then brought on to myself
2 as clinical coordinator, on to Dr. DeTraglia as
3 medical director, and then from there on to the
4 state.

5 MR. TAYLOR: Mark, what is the third
6 option from request, one is refer to your --
7 committee, one is the medical director --

8 MR. WILSON: All the way to the left
9 is issue resolved.

10 DR. DETRAGLIA: That means Mark took
11 care of it or it didn't happen.

12 MR. WILSON: Actually it would go
13 towards agency. The boxes all the way to the left
14 are the issues resolved, the one -- the next tier of
15 four, the one all the way to the left. Can everyone
16 read that?

17 (WHEREUPON, there was no response.)
18 MR. WILSON: Actions were
19 inappropriate. Down below that and all the way to
20 the left says if probation or suspension or
21 revocation consider. And the one to the right of
22 that is no. And then the one that connects below
23 that says yes.

□

8

1 MR. TAYLOR: Where does the agency
2 plug in with it?
3 MR. WILSON: The agency would be all
4 the way up at the top.
5 MR. TAYLOR: Okay. But the
6 resolution by the agency what do you have for that?
7 MR. WILSON: It could be any of the
8 top three, was the issue resolved within the agency
9 themselves; was it referred to the full committee
10 towards --
11 MR. TAYLOR: So the county committee?
12 MR. WILSON: Or was it referred on to
13 the medical director.
14 MR. TAYLOR: So that first box would
15 say something like issue resolved by agency?
16 MR. WILSON: Yes, you can put that
17 there. I am definitely opened for suggestions. Just
18 because it is in black and white doesn't mean that I
19 wrote it and that's the way it's got to be. Some
Page 7

20 people have a lot more experience than I do, and I'm
21 willing to take any constructive critiquing.

22 MR. BROEDEL: This is kind of the way
23 we have always done it. It's just never been typed

□

9

1 before and except for the size of the print.

2 (WHEREUPON, all Members responded with
3 laughter.)

4 MR. WILSON: It's basically -- I mean
5 this is all stuff that we kind of do internally in
6 here. It's just to let you guys know what we're
7 actually doing, so if you have a question on how the
8 process goes, then this lets you know how we refer to
9 the process.

10 MR. WRIGHT: Mark, just a question,
11 it refers to the committee, the county committee
12 or --

13 (WHEREUPON, Greg Wright could not be
14 heard.)

15 MR. WILSON: The county committee.

16 MR. WRIGHT: Okay. And the other
17 question is -- and I've asked this for a while, but I
18 don't know if I've ever gotten a great answer on it,
19 is if the agency resolves the problem inhouse, are
20 they covered by Article 30 because 3006 says you've
21 got to have a member of that and three different
22 parties?

23

MR. WILSON: Well, your medical

□

10

1 director is your physician. And then they ask for
2 usually an ALS provider or a BLS provider. They
3 would like to have one of each or a driver or --

4 MR. WRIGHT: I understand that, but
5 section 3006 spells out the exact membership of the
6 committee.

7 MR. WILSON: Right. It's actually in
8 that book.

9 MR. WRIGHT: Right. What I'm saying
10 is if you have an issue and you resolve it inhouse,
11 aye, nay or whatever. Okay. You should have done --
12 instead of doing A you should have done B. Okay.
13 Fine. Life is good. Now, there's a problem with
14 that call and it goes on to litigation. Is that
15 still protected under section 3006 because the
16 physician wasn't there or there weren't three people
17 who were not associated with the agency?

18 DR. DETRAGLIA: Believe it or not I
19 just read 3006 last night. And I would say that if
20 you resolve it in agency, you better be sure you have
21 those steps if not it'll come here.

22 MR. WRIGHT: That's my question.

23 DR. DETRAGLIA: The way I read it --

□

11

1 and believe it or not I read it just last night off
2 the internet, but it seems to be the way I read it --
3 and we can get some legal advice, but if you resolve
4 it inhouse and get us to this point, that's your
5 problem. Well, I don't mean that's your problem, but
6 you better have done it properly, and it no longer
7 becomes the REMAC's responsibility.

8 MR. WRIGHT: And after that it might
9 be kicked up to the county level to say this is what
10 we need to do. Because I can tell you that in the
11 county there are very few things that come out.
12 Either we're all doing great or it's not being called
13 appropriate. And I don't think we have to hang
14 anybody. Certainly that's not my intent. But I
15 think if people don't understand how it goes, that
16 discussion may then become discoverable if it goes to
17 litigation. And people who thought they had
18 confidentiality will suddenly --

19 MR. BROEDEL: I think the resolution
20 of this would be for an agency to resolve -- if they
21 do resolve it, to submit the entire package to the
22 region, who does have that makeup, and can at that
23 point agree or disagree. That's what I think.

□

12

1 MR. TAYLOR: That's what I think,
2 yeah. I think that if you accept this, for example,
3 you have accepted the idea that the agency can
4 resolve it and you've delegated that from this group
5 to that agency.

6 DR. DETRAGLIA: Exactly.

7 MR. TAYLOR: But I think that you're
8 crazy if you don't have a -- in there saying that
9 there has to be a report made back and accepted by
10 the group.

11 MR. BROEDEL: That would be that the
12 agency report should report to the region?

13 MR. TAYLOR: Yeah. At least -- if
14 you adopt this as your way of doing it, you and the
15 group are saying this is okay. Therefore I accept
16 this. So actually -- I would think, you are
17 satisfying 3006.

18 MR. WRIGHT: I just wanted to make
19 that clear.

20 MR. TAYLOR: That was the way I read
21 it.

22 DR. DETRAGLIA: I have to rush off
23 and I apologize. It won't ever happen again. It was

□

13

1 an absolute screw up in my office. There are a
2 couple of items. One is that I need to hereby

3 appoint John Rubin as a member of the REMAC since he
4 is a member of the Education and Protocol Committee
5 along with Dr. Kowalski. Any objections?

6 (WHEREUPON, there was no response.)

7 MR. BROEDEL: Just a little feedback.
8 Dr. Garrett used to represent Education. Dr. Garrett
9 doesn't represent Education any more.

10 DR. DETRAGLIA: And this is what I
11 understood from the Executive Committee. One other
12 item is that Mark mentioned that we did some roll
13 outs and some protocol reviews. And I went on a
14 couple of those. Another place that we went to was
15 Old Forge, and we sort of got some groans and moans
16 and the usual stuff. But they brought up a very
17 interesting point, and it has to do with something
18 that we should be perhaps more familiar with than we
19 are and that is snowmobile injuries. There were --
20 and I have the data. We spent a fair amount of time
21 on it. There are 110 snowmobile deaths in the
22 country between 2002 and 2003, which translates to a
23 year ago now. There were 110 across the country, and

□

14

1 we had ten in our region. I pulled them up from the
2 Syracuse Region Trauma Center. So we are a
3 substantial snowmobile area, which should be no news
4 to any of us. One of the things that the Old Forge
5 people said was that snowmobile accidents are

6 different from motorcycle accidents. We have it sort
7 of fixed snowmobile/motorcycle fly off the motorcycle
8 hit a tree, fly off the snowmobile hit a tree. Those
9 probably are valid. What they brought up were two
10 situations. One is the patient rolls off the
11 snowmobile in to the soft snow, and we make him a
12 trauma code yata, yata, yata, or we don't make him
13 trauma code. It depends on vital signs and so on.
14 The other part that they mentioned was that
15 snowmobilers (sic) wear protective clothing. They
16 often can slide along the ice and not be injured, and
17 they may have just simple extremity fractures. The
18 data is a little different than that. The very
19 little data that's available says that if you hit --
20 one of the objects that a snowmobiler will hit if he
21 falls off the snowmobiler is snow. And mounds of
22 snow can act as dangerous obstructions even though
23 it's soft snow. The other area that has come to the

□

15

1 floor is that snowmobile injuries will frequently
2 have -- and that is they'll break their spines and
3 won't notice it because they're cold et cetera, et
4 cetera. They don't complain of pain. The third area
5 is internal injuries are frequently missed. These
6 are young people. They maintain their vital signs.
7 They protect their integrity. They don't
8 decompensate (sic) into shock -- don't have

9 decompensation of their shock for perhaps a little
10 more bleeding, and they're always in rural areas.
11 And it may be best just to trauma code them all,
12 which is I think what we've been doing. Anyways
13 nobody knows. There's just no answer that I can
14 find. So we're going to try and design -- I've
15 gotten some data together, Vin, probably Mark and I
16 and maybe some people from Old Forge who deal with
17 most of these will try to design a new run sheet for
18 this winter. And winter is coming rapidly. And in
19 that we'll try to define ways that we can measure
20 whether these patients are potentially badly injured
21 or not badly injured or whether they roll over off
22 the machine in to the soft snow we ought to treat
23 them a little differently than we now treat them.

□

16

1 But we ought to try to do something to make it a
2 little more rational. And with your permission we'll
3 then proceed with that and present it back and
4 hopefully start if off with the people in Old Forge.
5 Maybe everybody in the area. We'll talk about that a
6 little bit. But if you hear we've got something
7 goofy going on with snowmobiles, that's pretty much
8 what we're up to. And I'm sorry I have to leave.
9 MR. WILSON: John, do you want to
10 talk about trauma criteria and pre-hospital just real
11 quick because you're a huge resource. There have

12 been a couple issues that have come up.

13 DR. DETRAGLIA: Yeah. Patient
14 refusal -- Bill and I sat and chatted about this for
15 a little bit. I talked to the people at St. E's at
16 the trauma center and talked to state people and John
17 Fortune, who is the new trauma director at the
18 regional trauma center in Syracuse. And we've come
19 up with a scheme that Dan -- not scheme.

20 (WHEREUPON, all Members responded with
21 laughter.)

22 DR. DETRAGLIA: We've come up with a
23 routine that Dan will describe, and I'll be happy --

□

17

1 I do support what -- we had several scenarios, and we
2 picked this one as what we thought was best. If you
3 agree, that's fine. If not, we'll be happy to put it
4 back on the drawing board. We will accept any
5 suggestions. But we did think this through, and I
6 did get some advice, and Dan will present it. Thank
7 you.

8 MR. BROEDEL: We'll just continue on
9 with the agenda.

10 MR. TAYLOR: Are we still on CQI?

11 MR. WILSON: Yes.

12 MR. TAYLOR: One of the questions
13 that I have with this is -- is this pretty much what
14 we've always done. There's no question about that.

15 I think that the agency's resolution there's a new
16 twist to it. One thing that I guess I bring before
17 the group is this I see no place in here where
18 there's an appeal. I, for example, am --
19 (inaudible). It goes through the whole thing, and we
20 get down to this committee and it goes to vote before
21 John DeTraglia. I feel this committee will go
22 through the whole thing and everything else, and I'm
23 not happy with the conclusion of the committee. Do I

□

18

1 have the right to appeal it above the committee to
2 the department of health? Especially if it's a new
3 protocol.

4 MR. WILSON: Yes, you do. In the
5 manual itself, the written manual, there is a policy
6 in there on how to appeal such actions.

7 MR. BROEDEL: Bob, did you have a
8 question?

9 MR. STURDEVANT: We used to do a lot
10 more at the county level than we do now. And I'm
11 reading this over and the first paragraph it says the
12 county level CQI Committee may only set educational
13 course of actions for providers. I have no problem
14 with that, but back in here it says -- they clearly
15 expect us to receive issues. Because they says the
16 county CQI issues that cannot be resolved at the
17 county level will be referred to the regional CQI

18 Committee for review. It lists the actions which
19 automatically comes to the regional committee. That
20 would lead you to believe that other actions, other
21 than what come here automatically, should go through
22 the county first.

23 MR. WILSON: They can go through the

□

19

1 county.

2 MR. STURDEVANT: I think what's
3 happening in the CQI -- especially at the county
4 level I think a lot of people are losing interest in
5 being there. And I think you need to make them feel
6 like they're doing something important other than
7 just sitting there and talking about the news that's
8 coming in from all over. Okay. I think maybe we
9 would have -- and we used to do that. We didn't get
10 in to trouble. I don't have a problem with major
11 things coming here first. I mean the county
12 committee should be aware -- at least the chairman
13 should be aware of what comes here and just know what
14 the results are. No names mentioned. It will be
15 something that's reported to the county committee.
16 And we did that for a long time. Dan did that
17 before. But I think the county committee needs to be
18 more active in something that makes them feel like
19 their sitting there for an hour doing something
20 that's important rather than just sitting there going

21 over the literature that we have here tonight.

22 MR. BROEDEL: Does the committee
23 believe that we should automatically refer back to

□

20

1 the county on issues, other than the ones that are
2 listed there? That sounds like --

3 MR. STURDEVANT: What I'm saying is
4 if Greg brings us an issue that somebody is not
5 taking blood pressures the way that they should be
6 through a call, they try to resolve it. They have
7 this particular individual counseled, and he
8 continues to do. Greg brings it to the county level
9 and asks if there's something that can be done, and
10 that it's at least reported and something done at the
11 county level.

12 MR. BROEDEL: Okay.

13 MR. STURDEVANT: Nothing can be done
14 without physician input. Dr. Grossman would have to
15 review it with the committee, sit down with the
16 committee, and maybe she would have a suggestion or
17 an idea on how to correct it there. If it can't be
18 corrected there, then it would come here. But, you
19 know, our attendance used to be a heck of a lot
20 higher than it is now when we were doing things.
21 Don't you agree, Greg?

22 MR. WRIGHT: Yeah.

23 MR. STURDEVANT: And according to

□

21

1 this booklet we're clearly supposed to be doing
2 things.

3 MR. BROEDEL: If there's no
4 objection, that would take a load off of Mark. And
5 it would be more involvement for the EMS providers in
6 the county if there was a --

7 MR. WRIGHT: Counties meet when?

8 MR. WILSON: Quarterly.

9 MR. WRIGHT: So you're going to run
10 up against time issues. And just like the Executive
11 Committee -- why not have an Executive Committee at
12 the county level. So that when issues come up, they
13 can met and discuss it with whoever this medical
14 director is what they found out and resolution and
15 solve it like that.

16 (WHEREUPON, all Members were
17 interjecting one another.)

18 MR. STURDEVANT: We can form an
19 Executive Committee formed here by these four or five
20 people that are required to be on it or should be on
21 it. One nurse, the EMS coordinator, a member from
22 dispatch and a member of the fire service/law
23 enforcement and one from an ambulance service. That

1 could be your Executive Committee. That's five
2 people which you need.

3 MR. BROEDEL: That's exactly the way
4 that Mark does it now only he does everything and
5 it's with the regional medical director. And there
6 are certainly no objection. We would have no
7 objections if the group doesn't.

8 MR. STURDEVANT: I have people who
9 say, "why should we be there? what do we do?" They
10 just sit there and hash over newsletters and stuff.
11 I don't know. We used to do that. The serious
12 things came here. We did things there. For
13 instance, there was an issue with somebody -- with
14 the automatic door locks on an ambulance. Remember
15 that night, Bonnie?

16 DR. GROSSMAN: Yes.

17 MR. STURDEVANT: Those kind of issues
18 I don't see why they need to float over here. I
19 think they're probably somethings that can be
20 resolved at the county level. I think we should have
21 to report to you whatever we resolve so that you have
22 it in your files. I think any decisions that we make
23 should be reported over here. The only thing that we

1 can do is remedial education is the only thing that
Page 20

2 we can do. We can't suspend anybody. We can't do
3 any of that kind of stuff.

4 MR. BROEDEL: Well, with the
5 permission of the REMAC can we take for the next
6 three months any issues that aren't listed here refer
7 those back to the county committees and report back
8 at the February REMAC how that's working?

9 MR. STURDEVANT: Yeah. That would
10 give us a meeting -- at least one meeting.

11 MR. BROEDEL: Any objection to that,
12 Mark?

13 MR. WILSON: No. I can -- I mean
14 you've got a unique animal out in Madison County
15 along with Herkimer County. They have a similar --
16 maybe not as structured, but similar committee or
17 forum that gets together to discuss these issues. I
18 can roll this out at the next CQI meetings, which are
19 in December, to try and bring the agencies that
20 participate up to speed also. That may be an extra
21 push to get them to do whatever the concerns are
22 here.

23 MR. STURDEVANT: You know, I just

□

1 think we need to offer the county people -- folks
2 more to do, something to make it more interesting for
3 them. And I think by doing that it will help them
4 internally in their CQI committees. They'll see how

5 to do different things and how to look for that. I
6 think it will help the whole process all the way
7 around.

8 MR. WILSON: I think that -- not to
9 beat a dead horse, but I think part of the problem
10 when it comes to CQI is that everybody has old
11 feelings about the audit and review.

12 MR. STURDEVANT: That was a big
13 problem, yeah.

14 MR. WILSON: And when you got turned
15 in audit and review, you were in trouble. We're not
16 looking to do that with the CQI process now. We want
17 to remediate, educate and provide a better patient
18 care than we may already be doing. And that is the
19 point that needs to be emphasized on to our providers
20 in that CQI isn't that hey, you're in trouble. CQI
21 is hey you may want to look at it from this aspect,
22 and this is how we can provide better customer
23 service, so to speak.

□

25

1 MR. STURDEVANT: We harped about that
2 a lot. And I think most of the people in our county
3 know that that's not the case any more. There was a
4 time when yeah, you're absolutely right. But I think
5 we've gotten past that.

6 MR. BROEDEL: Are there any
7 objections to a trial?

8 DR. GROSSMAN: Someone brought up
9 that the issues need to be resolved in thirty days.

10 MR. STURDEVANT: I think at the next
11 meeting we need to appoint an Executive Committee,
12 which you will obviously sit on, and that committee
13 will be the one that will meet in between meetings.

14 MR. BROEDEL: Each county will be
15 individual on how they set that up and it would be up
16 to the county CQI. Dr. Kowalski made a motion to try
17 that and Dr. Rubin seconded it. Any objections?

18 (WHEREUPON, there was no response.)

19 MR. STURDEVANT: And Mark will be at
20 our meeting, so he will know what we're doing and how
21 it's working or how it's set up, you know. So it
22 won't be any secret.

23 MR. WILSON: Right.

□

26

1 MR. BROEDEL: We'll report back in
2 February.

3 MR. WILSON: What's your percentage
4 of people in Madison County of the organizations that
5 actually participate in CQI?

6 MR. STURDEVANT: It's dropped off.
7 It used to be ninety-eight to ninety-nine percent.
8 But we were really -- you know, we were really
9 involved. We were doing things. But it's dropped
10 off. Greg keeps the roll call. It's dropped of

11 significantly.

12 MR. TAYLOR: Being a bit devious
13 perhaps those issues of participating members go
14 before the committee and the non-participating
15 members --

16 (WHEREUPON, all Members responded with
17 laughter.)

18 (WHEREUPON, all Members were
19 interjecting one another.)

20 MR. STURDEVANT: I'm a hundred
21 percent in favor of everybody -- a hundred percent of
22 participation in that county. It should happen.

23 (WHEREUPON, all Members were

□

27

1 interjecting one another.)

2 MR. BROEDEL: Okay. Listen. We have
3 another meeting to attend, so forgive me. We need to
4 keep going. Can we go off the record for just a
5 second.

6 (WHEREUPON, an off-the-record
7 discussion was held.)

8 MR. BROEDEL: Mark, protocol update?

9 MR. WILSON: Protocol update the
10 individuals that are on the committee have received a
11 letter from myself. I believe that everybody with
12 maybe the exception of Bonnie hasn't received copies
13 of all the submissions. I would like to meet next

14 month. In the early part of next month. If that's
15 all right. I would have to get in touch with those
16 people. If they can give me some feedback by maybe
17 the end of tonight, we can set something up. But I
18 would like to get the ball rolling now that we're
19 hopefully on the right track. Two quick things on
20 CQI. Reviews that have been submitted to me I have
21 one review that is open at this point just pending
22 paperwork from that specific agency. Otherwise,
23 we're all up to date. And about a year ago I

□

28

1 submitted a proposal to change the forms for
2 narcotics, the forms that are turned in by the
3 agencies telling me whether they used narcotics or
4 they didn't to try and standardize them. And I did
5 make copies of all the administrations that I've
6 received from January 1st until October of narcotics
7 that have been administered and in what agencies. It
8 will give you the month, the substance, how much was
9 administered and the reason for administration. I
10 think that's kind of interesting to look at.

11 MR. BROEDEL: Any questions for Mark?

12 (WHEREUPON, there was no response.)

13 MR. BROEDEL: The Program Agency
14 Report? Midstate medical control physicians the list
15 is on the table. The advanced providers Mark
16 supplied in the statistics. And controlled

17 substances agencies -- or agencies providing
18 controlled substances Mark has reported on. Any
19 questions for the Program Agency?

20 (WHEREUPON, there was no response.)

21 MR. BROEDEL: Old Business?

22 (WHEREUPON, there was no response.)

23 MR. BROEDEL: We've discontinued ALS

□

29

1 Bypass. The REMAC is charged with monitoring that.
2 Have there been any issues that anyone wants to bring
3 before the group?

4 (WHEREUPON, there was no response.)

5 MR. BROEDEL: Great. Okay. We're
6 going to skip the Air Medical for this moment.
7 Mental health? At the last REMAC meeting the mental
8 health was referred back to Anna's committee, the MHL
9 Committee. Ambulances have a duty to respond to an
10 EMS request. And we cannot pick and choose which EMS
11 request we're going to respond to. So Anna is going
12 to request if non-medical 941s have an obligation to
13 respond if they're available. We have sent a -- we
14 tried to send an education message back to the
15 deputies, the village law and the state police of the
16 critical shortage of EMTs, and what they're doing by
17 taking an ambulance out of service. We've had
18 positive feedback from several agencies and they're
19 avoiding using an ambulance to transport a

20 non-medical 941. It appears from our MHL Committee
21 that that is the best that we're going to be able to
22 do.

23 UNKNOWN SPEAKER: (Inaudible)

□

30

1 MR. BROEDEL: Legally an ambulance
2 that is in service and is requested has an obligation
3 to provide it.

4 DR. KOWALSKI: Once they get to the
5 scene can a mutual decision be made between the crew
6 and law enforcement?

7 MR. BROEDEL: I don't see why that
8 would be a problem.

9 DR. KOWALSKI: Because as a medical
10 control physician at resource I would have no problem
11 backing and being part of that decision and neither
12 would anybody else at medical control. We're
13 specifically talking about other -- Boonville, et
14 cetera.

15 MR. BROEDEL: Exactly.

16 DR. KOWALSKI: It was brought up at
17 the last two medical meetings.

18 MR. WILSON: I would see two things.
19 One would be liability on the service and whether law
20 enforcement accepts that responsibility.

21 DR. KOWALSKI: Well, if they don't
22 accept that responsibility, then the service cannot

23 sign off on it. They have to transport that patient.

□

31

1 And the services liability is covered by the medical
2 control physician.

3 MR. WILSON: Right.

4 MR. BROEDEL: He's saying that the
5 officer and the EMT agree that the patient doesn't
6 need to go by ambulance. The medical control doc
7 can --

8 DR. KOWALSKI: Let the agency respond
9 because they do have a liability to transport unless
10 they have medical control's okay on that.

11 MR. WILSON: But isn't it that if
12 you're placed under 941 by law you cannot refuse?
13 who would be the refuser? The patient cannot refuse.

14 MR. BROEDEL: The patient would still
15 go to the hospital.

16 DR. KOWALSKI: Correct. The question
17 is are they going to be transported by law
18 enforcement or the agency. Once the agency response
19 and they make patient contact there's some sort of
20 obligation to finish that call.

21 MR. WILSON: Correct.

22 DR. KOWALSKI: Or to turn the
23 responsibility over to the trooper.

1 MR. WILSON: I guess my question
2 would go towards the PCR and what would you write on
3 the bottom of your PCR as a disposition code?
4 Because you're not transporting. Do you write 004
5 treated by this unit transported by another?

6 MR. TAYLOR: Yeah.

7 MR. BROEDEL: Per Dr. Kowalski. Any
8 other comments on the MHL?

9 MR. WILSON: I have no objection. I
10 just want an answer so that when they call me up, I
11 can tell them this is what's up.

12 (WHEREUPON, all Members were
13 interjecting one another.)

14 MR. BROEDEL: Air Medical, Vinny?

15 MR. FARAONE: We met. Air Medical
16 met last week, Thursday, in fact. And we drew up a
17 new agreement that everyone in the room was
18 comfortable with. This is the agreement you see
19 before you. Mercy Flight representatives at the
20 meeting agreed that Mercy Flight would sign this
21 agreement. It's a good agreement. The problem is
22 that at five o'clock we got a phone call from Central
23 New York, Warren Darbey called me just a few minutes

1 ago, just before the start of this meeting, and said
2 that there has been a change in plan. Mercy Flight
3 is not agreeing to sign this agreement because of two
4 points. One point is on section C, Clearinghouse
5 priority, item number three, page one. It says here,
6 "On EMS calls in Onondaga County Air One will be
7 requested first if appropriately staffed and in
8 service." This has been a gentleman's agreement
9 between the air services for as long as I can
10 remember in the county of Onondaga, Air One would do
11 the call first. They don't fly out of the county
12 unless there's absolutely no other flyer available.
13 And that's more of a tax payer's issue. Tax payer's
14 really didn't want their helicopter flying out of the
15 county because they essentially pay for it. So it's
16 been an agreement. When New York State Police heard
17 this, they decided that they also had an issue. One
18 of the majors or generals or whatever they are from
19 the Albany area decided that it would not be
20 appropriate for Mercy Flight to be the first up
21 because they want the ability to rotate calls as they
22 do out in the Albany area. One week the private
23 people do it -- I don't know if it's one week or one

□

34

1 day. we have always done as part of one of the
2 benefits to try and convince Mercy Flight to come

3 back in to the fold we have promised them that they
4 would be first up in Madison and Oneida County
5 everything west of Utica and Life Net would be first
6 up everything east of Utica. So I thought we were
7 going to come here and have a resolution tonight.
8 But now there's a problem. When we met earlier,
9 Ross, Bill, Dan and I, and we were wondering if we
10 could come up with a way that we as Midstate
11 REMSCO/REMAC could accept this document as an
12 agreement to get Mercy Flight back in to the loop and
13 back as first up in those locations, west of Utica.
14 And let Onondaga County fight amongst themselves and
15 hash that out. As far as the state police, we really
16 have the authority, I believe, at least we've taken
17 that stand in the past, to appoint who we want as
18 first up. And if we feel that Mercy Flight should be
19 first up prior to the New York State Police, then I
20 guess we can make the grid reflect that. From a
21 patient care standpoint we have to admit that Mercy
22 Flight probably -- I don't want to step on anybody's
23 toes here, but Mercy Flight is providing a

□

35

1 nurse/paramedic. The New York State Police are
2 providing a paramedic. So we have to consider that.
3 UNKNOWN SPEAKER: (Inaudible) They
4 are essentially providing a higher level of care in
5 that regard. (Inaudible).

6 MR. FARAONE: I would think for that
7 reason alone we would be justified in appointing --
8 changing the grid to reflect Mercy Flight being first
9 up ahead of the state police for medical reasons
10 alone.

11 MR. TAYLOR: Okay. I have not had a
12 chance to read this. I'm just reading this section
13 over here. But where does it say -- where is the
14 commitment of Mercy Flight reporting to the
15 Clearinghouse their availability? Is it in there? I
16 just haven't seen it.

17 MR. FARAONE: It is. I don't know
18 where it is. Oh, here it is. It's section E, one.
19 "The participating AMS will update the Clearinghouse
20 as to its state of readiness on a continuous and
21 on-going basis, including availability to respond to
22 EMS calls."

23 MR. TAYLOR: That wasn't our issue.

□

36

1 We don't give a shit about the state police and
2 Onondaga County Air One. The issue was the
3 Clearinghouse, correct?

4 MR. FARAONE: Correct. Absolutely.
5 Like I said, I don't know how we're going to overcome
6 the fact that now we have -- we don't have the
7 Onondaga County Sheriff's and the state police are
8 not willing to sign the agreement. I don't know how

9 we'll overcome that. But I think if we accept this
10 document as an agreement of memorandum between Mercy
11 Flight and Midstate EMS, we can put them back first
12 up.

13 MR. STURDEVANT: It'll be our
14 standard of care.

15 MR. FARAONE: Right.

16 MR. WILSON: Can we just eliminate
17 number three and use this as a contract between
18 Midstate REMAC and Mercy Flight?

19 MR. BROEDEL: We can't do that
20 because that would separate us from the
21 Clearinghouse. This is a Clearinghouse agreement.
22 And at that Air Medical meeting the Clearinghouse
23 made it very clear that Mercy Flight was calling in

□

37

1 and calling out and making available all their
2 information and was a good participant in the
3 Clearinghouse. Our objection has been their lack of
4 participation. They have agreed to participate.
5 They have shown that they will participate. And it
6 seems that -- we left that meeting knowing that this
7 was going to be an issue.

8 MR. FARAONE: So if we make this an
9 agreement between Midstate and Mercy Flight, if those
10 guys are amendable to that, then we'll change the
11 grid to reflect our agreement. And whether they sign

12 the Clearinghouse agreement or whether we fight over
13 this for the next couple of years really won't be an
14 issue. I think that's an easy way out of this.

15 MR. BROEDEL: And it's the right
16 thing to do.

17 MR. FARAONE: Absolutely. I mean,
18 it's a patient --

19 (WHEREUPON, all Members were
20 interjecting one another.)

21 MR. BROEDEL: Right.

22 MR. TAYLOR: Now, Paul Highland is
23 going to sign this agreement?

□

38

1 MR. STUBBA: Actually I left the
2 meeting after almost three and a half hours that it
3 was the understanding that as things were addressed
4 and decided at that meeting it would be a signed
5 agreement until we got that call from Warren
6 concerning the fact that the state police disagreed
7 with this.

8 MR. TAYLOR: My concern -- we have
9 been going through this for a million years, and my
10 concern is not the state police. My concern has been
11 Paul Highland. And if he's willing to sign this
12 agreement, that says a lot to me.

13 MR. FARAONE: With the exception to
14 number three.

15
16
17
18
19
20
21
22
23

MR. TAYLOR: Right.
MR. FARAONE: He's not going to sign
this agreement. We're going to have to change this
agreement and change that one line about Onondaga
County.
MR. HOHAM: That was added in after
the meeting.
MR. WILSON: (Inaudible).
MR. TAYLOR: So he objects to some of

□

39

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17

this and this went in after your meeting?
MR. FARAONE: I'm not sure that's
entirely correct. We left there and they were going
to have a discussion afterwards, Onondaga Air One and
Mercy Flight were going to have a separate
discussion. It's always been a gentleman's agreement
between Onondaga and Mercy Flight that Onondaga would
fly first in the county because they don't fly out of
the county. The tax payers buy that ship, and they
support that program, and they want to see their ship
and their program being used.
DR. KOWALSKI: If we can make a
motion to move ahead striking that line, and if it's
not a signed issue, then we do have to bring up that
it's wasting a hell of a lot of resource's time.
MR. FARAONE: Right.
(WHEREUPON, all Members were

18 interjecting one another.)
19 DR. KOWALSKI: I understand that.
20 We're using a lot of people's time outside of this
21 meeting. I make a motion to move ahead striking that
22 one line as the issue, number three the last sentence
23 specifically, wasn't it?

□

40

1 MR. FARAONE: Right. The last
2 sentence. But also we have to change this agreement.
3 This will no longer be the Air Medical Committee
4 agreement. This will be an agreement and an
5 understanding between Mercy Flight and Midstate EMS.
6 And we'll just rewrite this and as long as you guys
7 agree with that we'll have Stanley sign it, Dr.
8 DeTraglia sign it and Mercy Flight, Paul Highland
9 sign it, and we'll all live happily ever after.

10 MR. STURDEVANT: And it will all be
11 the same except for that one sentence?

12 MR. FARAONE: Yes.

13 (WHEREUPON, all Members were
14 interjecting one another.)

15 MR. STURDEVANT: Great.

16 MR. BROEDEL: There's a motion on the
17 floor.

18 DR. GROSSMAN: Second.

19 MR. BROEDEL: Bonnie Grossman
20 seconded it. Any more discussions?

21 REMAC111604a.txt
(WHEREUPON, there was no response.)
22 MR. BROEDEL: All in favor?
23 (WHEREUPON, all Members responded with

□

41

1 ayes.)
2 MR. BROEDEL: Opposed?
3 (WHEREUPON, there was no response.)
4 MR. BROEDEL: Great. Mark, did you
5 get a protocol, Air Medical? We requested --
6 MR. WILSON: Yes. I requested
7 policies, procedures and protocols from Life Net out
8 of Glen. I was in contact with Debbie Funk, and she
9 has sent me a binder of those. So I do have those on
10 the premises as of yesterday.
11 MR. BROEDEL: Any other questions?
12 (WHEREUPON, there was no response.)
13 MR. BROEDEL: Moving on to New
14 Business?
15 (WHEREUPON, there was no response.)
16 MR. BROEDEL: Dr. Rubin was
17 appointed. Patients refusing the trauma center the
18 proposal -- the -- everyone has the protocol,
19 everyone has the letter from Ed Wronski. There have
20 been several issues that have been raised regarding
21 this and there have been several opinions including
22 the REMSCO that sent a letter to midstate requesting
23 a legal opinion on this. To cut through the chase,

1 like Dr. DeTraglia said, we've tried to figure out a
2 way to work this system, and we haven't. You all
3 have the memo. This is the way we would like to see
4 the system work or what we're proposing. When a
5 pre-hospital trauma criteria patient is identified by
6 the state protocol, the EMT or the AEMT will call
7 resource and the call will be directly sent to the
8 trauma center irregardless of disposition or injury.
9 The trauma center physician will hear the report,
10 make the determination whether the patient is okay to
11 go to another and okay to sign or make the call to
12 the trauma center. By doing that we're taking the
13 EMT out of the middle of this. We're taking the
14 agency out of this. We have a medical control
15 physician who is saying that it sounds like a sprain
16 and it's okay to go, or I need to speak with the
17 patient, hand him the cell phone and you really need
18 to come to the traumacenter. That's the proposal
19 that we have. There were several different things
20 that we looked at. Resource will be only used for
21 statistics for this. They'll flip the calls over
22 immediately to the trauma center. That will take the
23 resource doc off the hook for the trauma patient.

1 Suppose we try this for six months or three months?

2 DR. KOWALSKI: It's where the
3 appropriate decision should be at the trauma center.

4 (WHEREUPON, all Members were
5 interjecting one another.)

6 MR. WILSON: what would happen is
7 that there's an orange phone at St. E's --

8 DR. GROSSMAN: They'll be going to
9 St. E's.

10 MR. BROEDEL: You're just the closest
11 trauma center, yeah.

12 MR. WILSON: St. E's has an orange
13 phone that they receive wrong numbers on, and we'll
14 pretty much make that a trauma phone where they speed
15 dial at resource. If they hit trauma, it will
16 automatically ring that phone. This way St. E's is
17 aware that they have either a trauma or an MCI call
18 coming in. That's all -- it's a dedicated phone.
19 That's all it would be. From there we would hope
20 that if the patient refused to go to St. Elizabeth's
21 and we connected him to say, Oneida, that the doc
22 from St.E's would stay on the line along with
23 resource, the agency, and then Oneida, and the doctor

1 at St.E's can rely to Oneida what was evaluated and

2 that they're going to get the patient to go to their
3 facility.

4 DR. KOWALSKI: If the patient
5 absolutely refuses the medical control recommendation
6 for trauma center, has a decision been made as to
7 what to do about that?

8 DR. GROSSMAN: (Inaudible).

9 MR. BROEDEL: The docs at St.
10 Elizabeth's have to be able to make a patient
11 understand. It will have to be a doctor to patient
12 issue.

13 MR. WILSON: Right.

14 DR. GROSSMAN: I think it will go a
15 long ways for them. I think the EMTs will -- they
16 are so used to medical calls going with the flow.
17 They are not really comfortable pushing the patients.
18 Maybe now with the trauma doc behind them maybe
19 they'll be more likely to follow the protocol.

20 DR. RUBIN: And it will take the
21 responsibility off of them and put it on us.

22 MR. WILSON: Absolutely.

23 DR. RUBIN: Which is where it should

□

1 be.

2 MR. BROEDEL: Any other discussion?

3 (WHEREUPON, there was no response.)

4 MR. BROEDEL: Okay. Moving right

5 along. Mark?

6 MR. WILSON: We have to educate a
7 little bit.

8 MR. BROEDEL: December 1st?

9 DR. GROSSMAN: Do you want us to
10 write this at the bottom of the page? This is the
11 page where we're replacing, right?

12 MR. BROEDEL: Yeah.

13 DR. GROSSMAN: Do you want us to sign
14 that at the bottom?

15 MR. BROEDEL: Yeah, we'll do that,
16 and we'll send it out to the agency.

17 (WHEREUPON, all Members were
18 interjecting one another.)

19 MR. BROEDEL: Okay. Moving along.
20 The 12-lead program has been put on a hold from the
21 state. selective C-spine immobilization by
22 pre-hospital providers is -- the protocol that is
23 going to be coming -- the SEMAC is looking at several

□

46

1 different studies. It's just FYI that it's something
2 they're looking at, and they're going to include that
3 in the policy soon. I'm sure they're make a policy
4 statement. The SEMAC issue -- what do they issue,
5 advisories? Just so that you're aware. Well, here
6 we are at additional New Business.

7 DR. KOWALSKI: Can I bring up one
Page 41

8 thing for the table?

9 MR. BROEDEL: Sure.

10 DR. KOWALSKI: About two years ago,
11 maybe three years ago in the correctional rotation it
12 was a decision by REMAC that ever third patient in
13 the Oneida slash Rome rotation come to Utica. Well,
14 starting December 12th Faxton no longer exists as a
15 separate ED. And if you look at the numbers from
16 last month that's an additional 156 patients that are
17 going to be split between St. Luke's and St.
18 Elizabeth's. It's only a total of six more patients
19 in that rotation from last month for each facility,
20 St. Luke's and St. Elizabeth's from the Oneida
21 rotation. Can we think about it and bring it up as
22 an issue, or do we still want to continue separating
23 every third patient from the Oneida slash Rome

□

47

1 rotation and bring them to Utica?

2 MR. BROEDEL: I think that's a good
3 point. Utica is rotating the psych center and the
4 OCJ. And maybe a more equitable placement of these
5 patients back to Utica/Rome rotation and took Utica
6 out of the Oneida rotation.

7 DR. KOWALSKI: Or change the
8 Oneida/Rome numbers to fifty-six from last month, and
9 ours are going to go up to 230 each.

10 MS. O'ROURKE: We can't do that.

11 They take too much time.

12 MR. BROEDEL: Is that in the form of
13 a motion?

14 DR. KOWALSKI: Yeah, I would like to
15 make that a motion.

16 (WHEREUPON, all Members responded with
17 laughter.)

18 (WHEREUPON, all Members were
19 interjecting one another.)

20 MR. BROEDEL: There's a motion on the
21 floor.

22 DR. KOWALSKI: Look at the numbers
23 and if you really have an issue with it and want to

□

48

1 bring it back, hey, that's all right.

2 MR. BROEDEL: So we'll hold it off
3 until the next meeting?

4 DR. GROSSMAN: Let's vote on it next
5 time.

6 DR. KOWALSKI: I want to amend the
7 motion to bring it back and let's vote on it. That
8 was a lot easier.

9 MR. BROEDEL: Okay. It's tabled.
10 Finishing up.

11 (WHEREUPON, an off-the-record
12 discussion was held.)

13 MR. BROEDEL: We're on New Business.

14 DR. DETRAGLIA: New Business?

15 MR. WILSON: I have a proposal.

16 Everybody should have a copy of it. It was here on
17 the table. It's just a short stable ALS report
18 proposal. Being that we're consolidating an
19 emergency department the two Utica facilities
20 especially are going to be taking an increase in
21 patients. My prediction is that they are going to be
22 taking over 800 ambulances a month compared to about
23 680 to 700 that they're doing right now. So they're

□

49

1 going to be up in to over 800. As I stated earlier
2 St. Elizabeth's has one cell phone line besides the
3 dedicated trauma line that we're going to make now.
4 And to increase their ambulance flow is going to be
5 hectic to say the least. What I would like to do
6 is -- or am proposing is to do a two-month trial
7 study starting December 1st and running through
8 January 31st of 2005 to include St. Luke's Hospital,
9 St. Elizabeth's Hospital and Kunkel Ambulance only at
10 this point. They do the majority of the calls in the
11 city and they are really short of EMTs. I'm going to
12 guess that they're doing probably 800 to 900 calls a
13 month ALS in the city. What I would like to do is
14 abbreviate those reports as long as the patient is
15 stable. I've written everything out. One of the
16 things that we're hoping to do is increase the time

17 with the patient not only for the provider but for
18 the hospital staff themselves. They're not going to
19 be tied to the radio listening to people run on and
20 on and on on a report. Decrease the amount of air
21 time. And hopefully increase the confidence levels
22 of our ALS providers and get them more comfortable
23 with their skills. They know the skills and they

□

50

1 just need to slow down and complete them. Improve
2 emergency department perception of pre-hospital
3 providers. Let the doctors and the nurses in the
4 emergency rooms become more confident in the skills
5 and practices of our advanced providers in the
6 street. And in the long run it will hopefully reduce
7 some of the associated costs to the ambulances. On
8 the second page what I did was I put a mock box that
9 would include a portion of the information. Now,
10 I've talked to some emergency room physicians at St.
11 Luke's and at St. Elizabeth's, and this appears to be
12 the majority of what they're looking for. I did not
13 -- or I do not want to eliminate the possible
14 questioning of the emergency department to the
15 provider. I don't want to take that away. The one
16 thing you have to remember in regards to that is that
17 it's going to be a stable ALS patient. That's the
18 one word that I want to emphasize. Maybe I should
19 have put that in bold print. I want to emphasize

20 that it's going to be a stable ALS patient.

21 DR. GROSSMAN: (Inaudible) I think
22 it's just a matter of how -- it seems to me that --
23 and then they come back on the radio. I think it

□

51

1 would save a lot of time.

2 (WHEREUPON, Dr. Grossman could not be
3 heard.)

4 MR. WILSON: I'm not a hundred
5 percent sure on what's going to happen, but I would
6 at least like to try it. And you never know it may
7 be moving in the right direction.

8 MR. WRIGHT: This is just a comment
9 Syracuse has been doing this for years now. They
10 have had tremendous success with it.

11 MR. WILSON: I'm also in the same
12 sentence going to emphasize that we go back to the
13 short BLS report. I've seen a trend of increasing
14 BLS reports going over in the VHS radio. We need to
15 get back to the short criteria. BLS, you need the
16 age, sex, chief complaint, and give me an ETA.

17 MR. BROEDEL: We need a motion to try
18 this proposal.

19 MR. WILSON: what I would do -- over
20 the next two weeks, if we go ahead with this, I will
21 be in the process of educating both emergency
22 departments along with the nurse managers to bring

23 everybody up to speed and on board with this. And I

□

52

1 would educate the providers at Kunkel to bring them
2 up to speed with it.

3 DR. KOWALSKI: John made a motion and
4 I second it.

5 DR. DETRAGLIA: Thanks.

6 MR. WILSON: Is everybody comfortable
7 with the criteria that I wrote?

8 (WHEREUPON, all Members responded in
9 the affirmative.)

10 MS. O'ROURKE: It's good.

11 DR. RUBIN: I think it's going to be
12 getting it by the nurses that take the radio calls.
13 It would be somewhat difficult for them because
14 they're probably already used to it, which is kind of
15 a waste for the most part.

16 MR. WILSON: I think it's going to be
17 hard in the beginning. But I think once we get going
18 on it it --

19 DR. RUBIN: There's not enough time
20 to be standing at that box.

21 MR. WILSON: Right. And I think
22 that's what it's going to come down to. From there I
23 will do a study and give the recommendation at the

□

53

1 next REMAC meeting.
2 DR. DETRAGLIA: Additional New
3 Business?
4 MR. BROEDEL: If someone can bring us
5 up to speed on the Faxton closure?
6 MS. SCHENK: It's relocating.
7 (WHEREUPON, all Members responded with
8 laughter.)
9 (WHEREUPON, all Members were
10 interjecting one another.)
11 DR. KOWALSKI: (Inaudible) Depending
12 on who you talk to in the community including 911 one
13 night, and said, "my mom is real sick. I usually
14 take her to Faxton. Where should I go?" And they
15 tell them one second and come back and said St.
16 Elizabeth's or St. Luke's. The numbers have already
17 shifted. Faxton is seeing less people. But as of
18 December 12th it does not exist any more.
19 DR. DETRAGLIA: But a Kunkel rig will
20 be there just for people who come through the door.
21 The other thing is what is going to be the EMS
22 response to requests for Faxton? Is it going to be
23 automatic to St. Luke's, call resource, how do you

□

54

1 want to handle that?

2 MS. SCHENK: We won't accept
3 ambulances at the Faxton campus.

4 DR. DETRAGLIA: "I want to go to
5 Faxton and no place else."

6 DR. KOWALSKI: It no longer exists.

7 DR. DETRAGLIA: But I don't know.

8 MR. WILSON: It's going to be an
9 education on the providers themselves. Just like
10 when we used to do ALS rotations. "Faxton is closed.
11 would you like to go to St. Luke's or St. E's?"

12 DR. KOWALSKI: Here are your two
13 choices. Faxton doesn't exist as a hospital
14 anymore. Where else would you like to go.

15 MS. SCHENK: There's a huge public
16 relations process in place that's going to be rolled
17 out to educate the public.

18 DR. DETRAGLIA: Okay. That's kind of
19 what we're hoping for. But the one question -- and I
20 thought about this, if I were a guy out there driving
21 an ambulance and somebody says Faxton, tip, where do
22 you go next?

23 MS. SCHENK: Make another choice.

□

55

1 MR. BROEDEL: There's been a notice
2 that will be going out to the REMAC from Dr.

3 DeTraglia. Any ambulances Faxton/St. Luke's has
4 announced the closure of the Faxton Emergency
5 Department. Ambulance traffic at Faxton campus will
6 end on midnight on Saturday, December 11th.
7 Faxton/St. Luke's patients requesting transport to
8 the Faxton campus should be advised of the closure
9 and offer the St. Luke's Emergency Department.
10 Effective at midnight December 11th resource will
11 rotate patients with no request between St.
12 Elizabeth's and St. Luke's.

13 DR. DETRAGLIA: Do you want a Faxton
14 request to automatically go to St. Luke's?

15 DR. KOWALSKI: No.

16 (WHEREUPON, all Members responded with
17 laughter.)

18 DR. DETRAGLIA: The answer is no, so
19 write it down.

20 (WHEREUPON, all Members were
21 interjecting one another.)

22 DR. KOWALSKI: From a business
23 standpoint, yeah.

□

56

1 DR. DETRAGLIA: We're not talking
2 about business. We're talking about taking care of
3 people out on the street, and how do we protect our
4 providers, the EMS personnel. I hate to put it that
5 way, but we have to protect ourselves and them.

6 (WHEREUPON, all Members were
7 interjecting one another.)

8 MS. SCHENK: You can offer saint one
9 or saint two.

10 DR. DETRAGLIA: Right. I think
11 that's appropriate. And I know what the St. Luke's
12 people think. And I don't think you guys want all of
13 them, and I don't think anybody wants all of them at
14 this point. But I think appropriately for us as a
15 community problem we just want the EMS people out
16 there to know what they're supposed to do and what's
17 right.

18 DR. KOWALSKI: Off the record.

19 (WHEREUPON, an off-the-record
20 discussion was held.)

21 DR. DETRAGLIA: Well, I can see that,
22 and I can understand that.

23 (WHEREUPON, all Members responded with

□

57

1 laughter.)

2 DR. DETRAGLIA: Put on your patient
3 care hat. And that's understandable. And, you know,
4 I practice at St. Luke's and part of me wants all
5 those patients to go to St. Luke's. But I think
6 about the guys -- people who are out doing their job
7 that we're talking about, and they need to be
8 protected from this. They need to be outside of this

9 discussion. And I think offering them either of the
10 other two facilities gets everybody's chestnuts out
11 of the fire including the St. Luke's administration.
12 They don't want to be in a position where they're
13 forcing people one place or another. I don't think.
14 Thank you. So moved and accepted. Now, if the
15 ambulance comes from Rome --

16 (WHEREUPON, all Members responded with
17 laughter.)

18 MS. SCHENK: The actual patient
19 migration from the Faxton campus to St. Luke's will
20 start sometime after breakfast on the 12th.

21 DR. DETRAGLIA: And that's a Sunday.
22 So those will be transported by ambulance?

23 MS. SCHENK: Yes.

□

58

1 DR. DETRAGLIA: Do we have any -- if
2 I have --

3 MS. SCHENK: The entire Faxton
4 campus, the acute care, two medical surgical floors
5 and critical care and then the ER. They will all
6 have to migrate that day.

7 DR. DETRAGLIA: But that will require
8 during that day taking ambulances off the street. I
9 have a question about how many ambulances we can
10 afford to take off the street? who is going to do
11 the transport? Can we get ambulances from other

12 places?

13 MR. BROEDEL: Kunkel has contracted
14 with Faxton/St. Luke's to handle that. They are
15 going to maintain their normal level in the city, and
16 they have enough on the weekend.

17 DR. DETRAGLIA: Okay.

18 MS. O'ROURKE: Are you already
19 getting down so that your census is low?

20 DR. DETRAGLIA: Yes.

21 MS. SCHENK: There's no intention to
22 artificially deflate the census. There's some
23 decrease already, but they're not going to postpone

□

59

1 elective surgeries or admissions to the Faxton
2 campus.

3 DR. KOWALSKI: You're talking about
4 sixty-four inpatient beds?

5 DR. DETRAGLIA: Is that what it is?

6 MS. SCHENK: It's still going to be a
7 real effort. It's going to be -- the only acute
8 bed -- unit will be the acute rehab. And the whole
9 ambulatory surgery, oncology, outpatient oncology,
10 radiation, outpatient --

11 DR. DETRAGLIA: But St. Luke's has
12 been expanded so that there is no -- there are a zero
13 budget number of beds. They're not losing beds or
14 gaining beds. They are just being relocated.

15 DR. GROSSMAN: As well as the
16 outpatient services?
17 MS. SCHENK: Correct.
18 DR. DETRAGLIA: Unless you would like
19 to buy a hospital.
20 DR. KOWALSKI: You might want to
21 bring that back to the emergency medicine group at
22 St. E's. They might want to staff differently on the
23 12th. Faxton will not be receiving any ambulance

□

60

1 calls. We're changing our staffing to adhere to
2 that.
3 MS. SCHENK: And the hospital
4 Christmas party is the night before.
5 (WHEREUPON, all Members responded with
6 laughter.)
7 DR. DETRAGLIA: Anything else?
8 MR. STURDEVANT: I've got one issue.
9 A while back I brought before the REMAC a notice from
10 Morrisville Fire Department that they would -- after
11 they got out of their ambulance they were going to go
12 to an ALS rescue squad. They've dropped that, and
13 I've got the paperwork here. They're going to be a
14 BLS rescue squad. And I'll get a copy of this so
15 that it will be in your file. They're required to
16 notified you, like they're going to do. And then
17 we'll address it at that Ambulance Committee meeting

18 also.

19 DR. DETRAGLIA: Received and
20 acknowledged.

21 MR. STURDEVANT: Just so that it's on
22 record. That's all.

23 DR. DETRAGLIA: Anything else?

□

61

1 (WHEREUPON, there was no response.)

2 MR. LONCHEK: The date for the next
3 meeting is wrong on this.

4 DR. DETRAGLIA: Yes. The next
5 meeting will be on February 8th. Thank you. Good
6 night.

7 (WHEREUPON, the Meeting was
8 concluded.)

9 * * * * *

10

11

12

13

14

15

16

17

18

19

20

21
22
23

□

62

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23

C E R T I F I C A T E

I, Cynthia Belmonte, a Court Reporter
and Notary Public in and for the State of
New York, DO HEREBY CERTIFY that the foregoing
is a true and accurate transcript of my
stenographic notes in the above-entitled
matter.

Date: December 6th, 2004

Cynthia Belmonte

REMAC111604a.txt

□