

NEW YORK STATE
REGIONAL EMERGENCY MEDICAL
ADVISORY COMMITTEE

FEBRUARY 20TH, 2007

5:00 p.m.

* * * * *

Midstate EMS REMAC of Oneida
Madison and Herkimer Counties. Inc.
2521 Sunset Avenue
Utica, New York 13502

1 MEMBERS PRESENT:

2 John DeTraglia, M.D.

3 N. Nehrbauer, M.D.

4 Daniel Broedel

5 Jeff Fitzgerald

6 W. Joseph Taylor

7 Butch Hoffman

8 Vinny Faraone

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1 DR. DETRAGLIA: Okay. May we begin?

2 (WHEREUPON, all Members responded in
3 the affirmative.)

4 DR. DETRAGLIA: Do we have a quorum?

5 MR. BROEDEL: Yes, there is a quorum.

6 I know there are other people coming.

7 DR. DETRAGLIA: Do you want to wait?

8 MR. BROEDEL: Whatever you want.

9 DR. DETRAGLIA: Let's get started
10 because we have a presentation. We can begin.

11 (WHEREUPON, a Presentation by David
12 Hajdu regarding QuikClot was conducted.)

13 DR. DETRAGLIA: Thank you. Okay.

14 MR. BROEDEL: This is Matt.

15 (WHEREUPON, a Presentation by Matt
16 Riggins regarding EZIO was conducted.)

17 DR. DETRAGLIA: Thank you very much.

18 Correspondence?

19 MR. BROEDEL: We had two
20 correspondences, doc. This just came from the Oneida
21 County Emergency Communications. And I just want to
22 share this with you. This is from Fred VanNamee the
23 emergency services coordinator. "The attached letter

1 from AmCare Ambulance, Paul Taylor, is what makes
2 this job worth the rest of the agony. EMD did what
3 it is supposed to do give the paramedics and the
4 hospital staff an opportunity to utilize their
5 resources to help the victim. It is truly a team
6 effort. Too many times we are too focused on our
7 individual roles as members of the team. At dispatch
8 we seldom know the out come of the calls we dispatch.
9 I really appreciate Paul taking the time to let us
10 know in this case. I would like to suggest this call
11 for recognition at the EMS banquet next spring if you
12 decided to recognize the dispatch effort in some
13 way." This was a cardiac arrest patient on February
14 1st in the town of Western. Upon arrival the wife of
15 a forty-eight year old victim was performing CPR with
16 the direction of Dispatcher Kalk. The CPR was
17 effective, and the wife was calm, doing compressions
18 with her left hand and talking to 911 with her right.
19 They were able to revive the victim. And as of this
20 letter he is still alive. I just wanted to share
21 that with you.

22 MR. W. JOSEPH TAYLOR: And that
23 victim is a good ten miles from base. So it's not

1 like it was around the corner. A young man like
2 forty something.

3 MR. BROEDEL: Forty-eight.

4 MR. FARAONE: He's dead now.

5 MR. W. JOSEPH TAYLOR: Is he?

6 MR. FARAONE: Yeah.

7 MR. W. JOSEPH TAYLOR: It was a code
8 from hell. He went through at least eight different
9 arrhythmias on the way down.

10 MR. FARAONE: He made it to the ICU
11 for several days.

12 MR. BROEDEL: And the second letter
13 we got was from the Holland Patent Fire Department
14 with the intention of the Holland Patent Fire
15 Department to drop its ALSFR intermediate level
16 certification on January 31st. They'll be operating
17 at the BLS level starting in February.

18 DR. NEHRBAUER: Do they have a region
19 for that?

20 MR. BROEDEL: Manpower.

21 DR. NEHRBAUER: Manpower. What
22 geographic area are they covering?

23 MR. BROEDEL: Holland Patent is North

1 of --

2 DR. NEHRBAUER: How far is their
3 first response?

4 MR. BROEDEL: They have a pretty
5 decent size.

6 MR. HOFFMAN: Floyd to Stittville.

7 MR. BROEDEL: Barneveld.

8 DR. DETRAGLIA: Their main areas are
9 Prospect to the west -- to the east and north.
10 What's to the west and north?

11 MR. W. JOSEPH TAYLOR: To the west
12 and north from Holland Patent would be Boonville
13 north, Western west and Floyd south.

14 DR. DETRAGLIA: So it's a pretty good
15 chunk of real estate.

16 MR. W. JOSEPH TAYLOR: They just
17 don't have the people. I mean we gave them a
18 monitor. We gave them a LifePak ten to keep them
19 going. And they've turned the drugs and illegals in
20 to whoever. But they don't have anybody able to do
21 ALS level anymore. Bobby Sterling was there. He's
22 moved to Boonville. And a couple of others have
23 moved out. There's just nobody there. The closest

1 now would be for ALS either Prospect Ambulance or
2 Stittville Fire.

3 MR. BROEDEL: Just a sign of the
4 times.

5 DR. DETRAGLIA: They're not willing
6 to contract with a professional --

7 MR. BROEDEL: They don't do too many
8 calls. It's a small operation. And they really
9 weren't doing an awful lot of advanced work to begin
10 with. It was nice to have them there. But they
11 really didn't do a lot.

12 DR. DETRAGLIA: Can we cut up their
13 area to ALS services and extend --

14 MR. W. JOSEPH TAYLOR: Well, Prospect
15 covers that now. And we come up on the south and
16 Kunkel will come in from the other side if they need
17 it. And Kuyahoorra will come over if Prospect is not
18 available. And that's all.

19 DR. DETRAGLIA: So we do have
20 contingency?

21 MR. W. JOSEPH TAYLOR: Yes.

22 DR. NEHRBAUER: Shouldn't we write
23 them and make sure they have a contingency plan in

1 place or call them?

2 MR. BROEDEL: They've actually given
3 it to us. We have it in the form of mutual aid.

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

6 DR. DETRAGLIA: What else?

7 MR. BROEDEL: There was another
8 correspondence, and that's from the Sherill/Kenwood
9 Fire Department. And that's just notifying the REMAC
10 that they're adding a second ALS vehicle. And that
11 will be all for the correspondences.

12 DR. DETRAGLIA: SEMAC? Our regional
13 protocol has requested that it is in compliance with
14 the American Heart Association Guidelines. We knew
15 when we wrote them that we would have to be, and we
16 are. The last SEMAC meeting was actually cancelled
17 because of the snow storm, so we'll be going to the
18 next one. Okay. Clinical Coordinator, Vinny?

19 MR. FARAONE: There are a couple of
20 things. We're going to reintroduce the ALS
21 intercepts. We did some, and we got some returns.
22 But we really didn't introduce it the best way, so
23 we're going to reintroduce that sometime this spring.

1 Edwards has done their -- or started their
2 capnography study. And they're supposed to send me a
3 sheet -- a CQI sheet that they were using. I didn't
4 make it to the meeting. They have since used it. In
5 fact, the other day they had that pediatric arrest
6 and a tube became dislodged and the alarm went off on
7 the capnography and alerted them that the tube was
8 dislodged. So they immediately corrected it. So far
9 they've done this with two or three patients with it.
10 That will continue for another month, and then
11 they'll get back to us. PAD, we've added several PAD
12 agencies in the last couple of months. There's a
13 service here in the city a computer system added one,
14 Crouse Community Hospital extended care added one,
15 Schuyler Fire Department in the town of Schuyler both
16 added AEDs, Mohawk Fire Department added an AED,
17 Vernon Downs added an AED and United Food Workers
18 added an AED. I have one application that's pending.
19 I sent that to the state. I haven't gotten that back
20 yet. Stanwix Heights had become an Epi agency. And
21 medical control physicians we've added fifteen new
22 medical control physicians since our last meeting
23 mostly at Faxton/St. Luke's. The list is over on the

1 table there. Protocol updates we've updated three or
2 four providers that missed the updates, were out of
3 the area for whatever reason. Holland Patent went
4 over to basic. And the aspirin, there's a draft
5 protocol for the aspirin. Do you want to do that now
6 or under Old Business?

7 MR. BROEDEL: Get an agenda.

8 MR. FARAONE: Okay. We'll do the
9 aspirin later?

10 MR. BROEDEL: Yeah.

11 MR. FARAONE: This was the sheet, if
12 you guys want to look at it, that's what we used for
13 Edwards Ambulance with the CQI study.

14 MR. BROEDEL: How long was that going
15 to be going on?

16 MR. FARAONE: I think we talked about
17 two or three months.

18 DR. DETRAGLIA: Six months.

19 MR. FARAONE: Oh, okay.

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

22 MR. FARAONE: And the other stuff
23 that I have are the current CQI issues. There is a

1 two-page report. There is a 2006 report -- it's
2 dated November of 2006. It has all the issues that
3 we handled in 2006. Most of them are closed. If you
4 look at '06, seventeen, eighteen and nineteen, those
5 three are pending. Those were done like during
6 December. And I actually have answers to two out of
7 three of them. I have letters in response that you
8 need to look at and say aye or nay. There's one
9 that's always going to be open in our eyes. It's the
10 one way back when, '06-08. That was handed over to
11 New York State Department of Health.

12 MR. BROEDEL: Off the record.

13 (WHEREUPON, an off-the-record
14 discussion was held.)

15 MR. FARAONE: The state is handling
16 that. And then for 2007 there are two. I'm looking
17 at them right now. And again this '07-01 I have a
18 response for your approval, doc, from the agency.
19 And then the '07-02 that was an issue of calling the
20 wrong agency for a narcotic.

21 DR. DETRAGLIA: Where is that?

22 MR. FARAONE: On page two. Do you
23 have page two?

1 DR. DETRAGLIA: No.

2 MR. FARAONE: This page one was '06.
3 I have two in '07. And '07-02 was a controlled
4 substance meet up, and they called the wrong agency.
5 It's been addressed in house. The provider claims
6 that he didn't know that the other agency who had
7 controlled substance was closer. It's been addressed
8 by the training officer in house. They're going to
9 discuss it formally at their next meeting, which is
10 the end of this month. And then they will send us
11 back a written report of what the remediation will
12 be. Any questions about any of that?

13 (WHEREUPON, there was no response.)

14 MR. BROEDEL: Vinny, you might as
15 well do the Air Medical.

16 MR. FARAONE: You have the Air
17 Medical Report. That's all the calls that were done
18 in 2006. That's a pretty thick packet. It's
19 complex.

20 DR. DETRAGLIA: Vinny, did you get my
21 message about a call for a burn victim up in -- I
22 can't remember where it was.

23 MR. FARAONE: Yes, I did. We need to

1 chat about how you want to handle that, other than do
2 you just want to make a notification to the agency?
3 These are the air medicals. It's just the stats for
4 the year. And that pretty much just says the stats.
5 It tells you on the day and where they went, whether
6 it cancelled. It's interesting bathroom reading. We
7 went to the air medical meeting and nothing has
8 really changed.

9 MR. HOFFMAN: Are they pushing for
10 Mercy again? Are they going to call us directly?

11 MR. FARAONE: They're out of the game
12 right now. They're on a call us directly kick.
13 They're not going to participate in the Clearing
14 House.

15 DR. DETRAGLIA: Come off the record
16 for a second.

17 (WHEREUPON, an off-the-record
18 discussion was held.)

19 DR. DETRAGLIA: We can go back on the
20 record saying that multiple air medical issues were
21 discussed. And the plan will be to review with the
22 State Air Medical Committee the possibility of
23 developing pathways and indications for helicopter

1 service. End of story.

2 MR. W. JOSEPH TAYLOR: It's never
3 going to go away.

4 DR. DETRAGLIA: Old Business?

5 MR. BROEDEL: There's a new basic
6 life support protocol that was approved by the state
7 for the administration of aspirin. The state was --
8 their protocol at 162 to 325 milligrams. I earlier
9 asked you if we could get clarification for our
10 region, so that the medical directors could direct
11 the agencies in the correct dose. And your letter
12 indicated that a 162 milligrams, since that is our
13 standard dose, will be done. A letter went to every
14 ALS agency medical director suggesting to them that
15 we stick at 162 milligrams for a basic as well as
16 advance protocol. In that letter it also showed each
17 medical director and the agency what they were
18 responsible for. I'm not sure if you need to -- or
19 if you're just comfortable with it, but that's the
20 way it is.

21 MR. W. JOSEPH TAYLOR: Now, this is
22 the policy statement?

23 MR. FARAONE: That's the policy

1 statement. It has to be approved.

2 MR. W. JOSEPH TAYLOR: It says all
3 agencies must have an agreement with their medical
4 director. All current providers must be updated by
5 7/01/07. Is it BLS agencies?

6 MR. FARAONE: It says all BLS
7 agencies. Does it not say all BLS agencies?

8 MR. W. JOSEPH TAYLOR: It does not
9 say it. It says all agencies.

10 MR. FARAONE: "All Midstate BLS
11 providers are approved to administer 162 milligrams
12 of nonenteric chewable aspirin to adult cardiac
13 related problem patients. Administration must be
14 consistent with NYS EMT-B Basic Life Support
15 Protocols. All agencies must have an agreement with
16 their agency medical director. All current providers
17 must be updated by 7/01/07. Agency training files
18 should contain a roster of updated providers
19 including when, where, and who provided the update."

20 MR. W. JOSEPH TAYLOR: I'm just
21 asking if you want to put BLS in front of agencies?

22 MR. FARAONE: It says all midstate
23 BLS providers in the first sentence, Joe. "All

1 midstate BLS providers." Do you want something else?

2 MR. W. JOSEPH TAYLOR: No.

3 MR. BROEDEL: Is it okay to take that
4 protocol and send it in?

5 DR. DETRAGLIA: Yes.

6 MR. BROEDEL: That's it for that.

7 DR. DETRAGLIA: Old, New Business?

8 MR. BROEDEL: The Program Agency
9 received one complaint on a service, and we're in
10 process of reviewing that. It's the delay of
11 floating a patient. And we really can't speak of it
12 because it hasn't really been reviewed. Stroke
13 Center, St. Luke's Stroke Sense Committee is meeting
14 tomorrow night, and Vinny and I will both be
15 attending that. They're continuing to work toward
16 their stroke designation. There's a letter in the
17 handouts from physio-control. Physio-control has
18 voluntarily suspended shipping all products until
19 they can clear up some sort of an issue. So our
20 12-lead reader has been ordered and would have been
21 shipped, but it's sitting on the dock. So that's
22 where we're at with that. Vinny spoke of the air
23 medical clearing house. There have been no -- there

1 was one issue in the mental health -- MHL transports
2 regarding the MHL 941 of a pregnant female. They
3 thought it might have been an inappropriate
4 designation.

5 MR. FARAONE: But it wasn't pregnancy
6 related. It was just that she just happened to be
7 thirty-two weeks pregnant and a 941.

8 DR. DETRAGLIA: Okay.

9 MR. BROEDEL: That covers the Old
10 Business that I'm aware of.

11 DR. DETRAGLIA: New Business?

12 (WHEREUPON, there was no response.)

13 DR. DETRAGLIA: Any additional Old
14 Business?

15 (WHEREUPON, there was no response.)

16 DR. DETRAGLIA: I can't think of any.
17 New Business?

18 MR. FITZGERALD: Can I just ask a
19 real quick question?

20 DR. DETRAGLIA: Yes.

21 MR. FITZGERALD: Is the -- do you
22 know whether Faxton/St. Luke's are they still going
23 with the concept of having this kind of pump contest

1 where they're going to allow outlining -- (inaudible)
2 -- to start treatment?

3 MR. FARAONE: Once they become a
4 stroke center they'll be able to do that and offer
5 that service.

6 MR. FITZGERALD: Why is Syracuse --
7 do you see what's happening in Syracuse at Upstate
8 University? They're marketing their stroke center.
9 But I haven't heard anything at Rome that -- I mean,
10 is anybody else around here doing a HUB?

11 DR. DETRAGLIA: The HUB in Oneida is
12 a spoke for Upstate.

13 MR. FARAONE: Hamilton Hospital and
14 Little Falls are going to become spokes for
15 Cooperstown and Bassett. The equipment has been put
16 in place, but there's a problem making it happen.
17 There's a protocol issue. Rosie, said that there was
18 an issue with the protocols. So they're not actually
19 up and running yet.

20 DR. DETRAGLIA: What equipment?

21 MR. FARAONE: The telemedicine is in
22 place.

23 DR. DETRAGLIA: Oh, okay.

1 MR. FARAONE: But there are some
2 protocol issues. And I'm not sure what the issues
3 are. I'm afraid that one of the issues may be --
4 once this patient is determined to need a TPA, then
5 Hamilton Hospital, Little Falls Hospital and Oneida
6 Hospital really aren't capable of handling patients
7 that have TPA. So part of it is that there has to be
8 a transfer as part of that protocol.

9 (WHEREUPON, all Members were
10 interjecting one another.)

11 MR. W. JOSEPH TAYLOR: That's the way
12 it was discussed.

13 MR. FARAONE: Correct. And I think
14 that might be what's holding it up.

15 MR. FITZGERALD: That's why they're
16 doing it telemedicine. So that he can --

17 MR. FARAONE: And then the patient
18 transfer.

19 MR. FITZGERALD: Right.

20 MR. FARAONE: From conversations that
21 I've had with some of the ED directors, the nursing
22 directors, I think that's part of the glitches. And
23 they haven't worked out those protocols -- the

1 transfer protocols yet. That's one of the issues.
2 The equipment is in place. They're just waiting to
3 settle the protocols.

4 MR. FITZGERALD: I think the ICU --
5 (inaudible).

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

8 DR. NEHRBAUER: For a HUB hospital
9 that has a patient -- a small hospital like Little
10 Falls where it's an automatic transfer out and then
11 trying to find an accepting hospital -- it's not
12 necessarily you're a HUB hospital -- (inaudible) --
13 for lack of a ICU bed and won't take the patient at a
14 transfer in the ED. And that's where I think is the
15 problem. And that has happened throughout --

16 MR. FITZGERALD: Well, they won't
17 actually starting beginning until they get their
18 transfer agreed to. They won't start.

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

21 DR. DETRAGLIA: The thing of the care
22 is that a CT negative stroke -- CT negative, meaning
23 no bleed within three hours gets systemic TPA.

1 There's a six to eight hour window that's been talked
2 about, but really is not standard of care as far as I
3 know. We've talked about this frequently. There's a
4 six to eight hour window when a guy can stick a
5 catheter into the middle cerebral artery and clot it
6 out or pull it out or whatever. And that's the part
7 that is difficult to get around because we have
8 transport times. We have other issues. 24/7
9 availability of angiographic sweeps (phonetic) and
10 things like that. The HUB and spoke concept, I
11 think, is very appropriate, but I think that the use
12 and the ability to transfer and the ability to take
13 advantage of these high tech treatments is very
14 limited. I can foresee in this area five cases a
15 year, two cases a year within the time.

16 DR. NEHRBAUER: That's the window.

17 DR. DETRAGLIA: Right. We have
18 noticed some problems in our emergency room at St.
19 Elizabeth's that when a patient comes in know the
20 time they went down. And we know -- and we have
21 immediate availability of the CAT scan. And all of
22 the things -- everything goes exactly the way it's
23 supposed to, and we hit very close to the time.

1 DR. NEHRBAUER: Three hours?

2 DR. DETRAGLIA: Yeah.

3 MR. BROEDEL: We'll find out more.

4 DR. NEHBRAUER: And the problem with
5 the outline pilot is giving that drug with its known
6 complications.

7 MR. FARAONE: Right.

8 (WHEREUPON, all Members were
9 interjecting one another.)

10 MR. FARAONE: SUNY doesn't have a
11 bed, so where are we going to send this patient?

12 MR. FITZGERALD: And then if there's
13 a complication, why wait for a bed somewhere. That's
14 the problem nobody wants to take it.

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

17 DR. DETRAGLIA: Thrombolytics are
18 being used in town. They're given to stroke
19 patients, CAT scan negative stroke patients on a
20 fairly regular basis is my understanding.

21 MR. FITZGERALD: Because there's no
22 designated stroke center around here. Luke's does it
23 and don't you guys?

1 DR. DETRAGLIA: Oh, yes.

2 MR. FITZGERALD: But you have more
3 neurosurgical coverage too, right?

4 DR. DETRAGLIA: Yeah, there is some
5 coverage.

6 MR. FITZGERALD: But the problem is
7 that there's, what, ten percent of a negative CT that
8 could potentially have a small bleed that's not being
9 read.

10 DR. DETRAGLIA: It's almost as if
11 this is a center looking for a place. It's almost as
12 if we have the technique, and we have the technology,
13 so now let's find a way to make it work rather than
14 adapting the technology to the situation. It seems
15 we're doing it backwards. But the one thing that has
16 happened is that the marketing of stroke centers
17 throughout the state has been amazing, just amazing.

18 DR. NEHRBAUER: The problem is TPA is
19 probably better for coronary arteries than it is for
20 cerebral arteries. And unfortunately there isn't
21 another drug around that doesn't have the
22 complication rate the TPA rate has.

23 DR. DETRAGLIA: In our infinite

1 wisdom in this state we have stroke centers and don't
2 have STEMI centers.

3 MR. FARAONE: Oh, they're coming.
4 But that whole stroke center thing happened very,
5 very quickly. Don't you think that the whole spoke
6 and HUB concept -- because EMS complained at the
7 state level saying, "hey, we can't be taking our
8 little voluntary services and sending them to stroke
9 centers." I think that they addressed that very
10 quickly.

11 MR. W. JOSEPH TAYLOR: Three years
12 ago when doctors whoever came in and made the
13 presentation to the Article 30 Council about this
14 thing coming about -- and as I said to them then you
15 better get your docs in order. You've only got about
16 fifty percent of your docs that believe and will
17 follow this concept anyways. EMS will do what you
18 tell them to, but your docs aren't going to do what
19 you tell them.

20 MR. FARAONE: Yeah, you've got to get
21 those guys on board.

22 DR. NEHRBAUER: The problem is the
23 complications. It takes one or two cases as an ER

1 doc to see tremendous intracerebral bleeding after
2 TPA, before you become a little -- (inaudible) -- to
3 give this drug. It's not like giving it to a heart
4 patient where you're doing it, you're temporizing and
5 they're going to the CAT lab.

6 DR. DETRAGLIA: There are some other
7 aspects to this. I think stroke centers are
8 important not because of TPA, not because of
9 intervention radiology, but in the care of these
10 patients.

11 DR. NEHRBAUER: It's like the burn
12 centers.

13 DR. DETRAGLIA: Like burn centers,
14 exactly. It's been shown that these patients do
15 better when they're treated by a neurologist in a
16 neuro ICU verses being treated by a non-neurologist
17 anywhere. Now this is changing because everybody is
18 getting a little smarter now that -- or getting more
19 educated now that stroke centers have come along.
20 But people need to start looking at fluid balance,
21 PO-2s. I mean things that we do in a pre-hospital
22 setting, we look at airways. We look at blood
23 pressures. We look at hydration. We look at sort of

1 the standard things. And this is -- I think this is
2 going to come from stroke centers. It's more
3 sophisticated resuscitation and rehab. Strokes are
4 now out of the hospitals quickly, getting over to
5 rehab, and all those other fancy titles. And the
6 interesting thing is that for the length they're
7 staying for stroke patients in stroke centers has
8 gone way down. Years back it was the use of TPA.
9 They have three-day hospitalizations now and they go
10 to rehab centers. At least that's what we heard at
11 the last SEMAC.

12 MR. W. JOSEPH TAYLOR: It's three
13 hours and your window is so small.

14 MR. FARAONE: Exactly.

15 MR. W. JOSEPH TAYLOR: And most
16 strokes that we find in the field are discovered in
17 the morning when Uncle Charlie doesn't move the way
18 he should. So we have no idea when it occurred
19 anyways. Or they're found on the floor. So you have
20 no idea. So you've blown three hours there. And
21 it's unusual to get someone who saw the stroke
22 happen.

23 MR. FARAONE: That doesn't happen,

1 no.

2 DR. DETRAGLIA: Well, we'll keep that
3 going.

4 MR. FARAONE: We'll know more after
5 that.

6 DR. DETRAGLIA: New Business?

7 MR. BROEDEL: At St. Luke's
8 administration did say that there would be an
9 appointment made to this committee, a letter with an
10 appointment to you before the next meeting. And from
11 the Program Agency you need to know that we have been
12 reassigned administrators and we now answer to Rita
13 Popeo as our administrator. And you got a letter
14 from Marjorie Geiger from the department of health
15 regarding MOLSTs forms. I just passed out the letter
16 that doc got. This has been discussed at the State
17 EMS Council and approved for two regions. And I see
18 now that it's statewide. And I have not heard
19 anything at the state EMS level about the application
20 of the MOLST form. So I think it's coming, and it's
21 something we need to know that it's coming. But,
22 again, I haven't heard anything or seen anything at
23 the EMS level about the recognition of MOLST.

1 DR. DETRAGLIA: I think it was to be
2 discussed at the last meeting.

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

5 MR. BROEDEL: And there was -- are
6 these for nursing home patients?

7 MR. HOFFMAN: Nursing homes.

8 MR. FARAONE: Not necessarily but
9 seriously ill.

10 MR. HOFFMAN: Well, I see all the
11 pronouncements in the field on PCRs. And I'm seeing
12 a lot of MOLSTs attached to them.

13 MR. BROEDEL: Very good. And
14 hopefully we'll find out more.

15 DR. DETRAGLIA: The Monroe Livingston
16 Coalition (phonetic), I think they call themselves,
17 for MOLST will make a presentation. And it's
18 excellent. It's very well done. This is different
19 from a DNR. It's actually medical orders for --
20 (inaudible). It's statewide. I'm sure we'll hear
21 about it. I'm sure it would have come up at the next
22 meeting when we weren't there.

23 MR. BROEDEL: I have not seen

1 anything about it.

2 DR. DETRAGLIA: Right.

3 MR. FARAONE: Butch, is not one of
4 the advantages of this is to be very specific?

5 MR. HOFFMAN: Absolutely.

6 MR. FARAONE: Like I don't want this,
7 I want that.

8 MR. HOFFMAN: Do CPR, start an IV,
9 don't give me any medication. It's all mapped out.

10 MR. FARAONE: Okay.

11 DR. DETRAGLIA: Nicely done, I think.

12 MR. BROEDEL: Under additional New
13 Business, Greg Wright brought to my attention that
14 blood sugar monitoring is a BLS skill. And I know
15 our region has decided not to do that because of a
16 training and the calibration and a hundred other
17 reasons. Part of what Greg mentioned to me was
18 patients with blood sugars over four hundred now are
19 not candidates for stroke center. So his thought was
20 that we need to think about making the testing of
21 blood sugar a BLS skill once again. I think we need
22 to think very seriously about this. There's not much
23 the basic EMT -- it will not change his care at all.

1 The ambulances in our region all, with the exception
2 of two, monitor blood sugar. If we put glucose
3 sticks for BLS providers, there's going to be a huge
4 training issue, a huge calibration and record keeping
5 for very small BLS agencies.

6 DR. DETRAGLIA: Let's go off the
7 record.

8 (WHEREUPON, an off-the-record
9 discussion was held.)

10 MR. W. JOSEPH TAYLOR: The thing is
11 that it's not going to effect BLS care.

12 MR. BROEDEL: Not at all.

13 MR. W. JOSEPH TAYLOR: So why?

14 MR. BROEDEL: What Greg didn't
15 understand I think was that it may change the
16 delivery of where you're going to take the patient.
17 But the ambulance is going to take the patient. The
18 BLS provider is only going to give him -- (inaudible)
19 -- sugar or whatever. Greg didn't think it through,
20 but I promised him that I would bring it up for
21 reconsideration of monitoring blood sugar by BLS
22 agencies.

23 MR. W. JOSEPH TAYLOR: I think the

1 answer is -- regardless of the whole training issue,
2 is that under the BLS protocols it's not going to
3 effect the care of the patient. There's nothing that
4 they can do.

5 MR. BROEDEL: Right.

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

8 MR. FARAONE: But also our protocol
9 says you have to call an ALS organization. So, I
10 mean, ALS is going to be getting called on every one
11 of those cases.

12 MR. W. JOSEPH TAYLOR: If ALS is
13 available. It's not going to make them more
14 available.

15 MR. FARAONE: No, no. I know.
16 They're going to call for ALS as to what hospital is
17 going to be the closest.

18 MR. BROEDEL: At Greg's request I
19 brought it up.

20 DR. DETRAGLIA: Well, I think the
21 answer to him would be is that as most things that
22 come across we think we can do this from a training
23 and educational prospective, but to what end?

1 MR. W. JOSEPH TAYLOR: That's it.

2 MR. BROEDEL: Fair enough.

3 DR. DETRAGLIA: Anything else?

4 MR. BROEDEL: We need to know what to
5 do about the IO at least, approval for the use of
6 pediatrics.

7 DR. DETRAGLIA: I think it's been
8 approved for pediatric use if agencies are willing to
9 purchase this equipment for pediatrics. That's an
10 individual agency proposition. I think at this cost
11 I can't imagine most agencies would do it.

12 MR. BROEDEL: Doc, are you being
13 specific to the drill type -- or the gun type in
14 that --

15 MR. FARAONE: That's for chest only.
16 We don't do --

17 MR. HOFFMAN: No, we don't.

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

20 DR. DETRAGLIA: Let's discuss it this
21 way for pediatrics we will approve mechanical
22 devices. And then let the agencies decide what they
23 want to use, how they want to educate, and how

1 they're going to get back to us. So we will approve
2 mechanical devices subject to training.

3 MR. W. JOSEPH TAYLOR: Record
4 keeping, medical director advising, protocols.

5 MR. FITZGERALD: But they still
6 should know how to do it manually.

7 DR. DETRAGLIA: Absolutely. That we
8 know we've educated in training.

9 MR. FITZGERALD: I mean they don't
10 want to lose that component if they have a failure --
11 a mechanical failure or something. If somebody comes
12 on, they need to know how to do that as back up.

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

15 DR. DETRAGLIA: But for adults what
16 do you think?

17 MR. FARAONE: You have to have a
18 protocol to approve it.

19 DR. DETRAGLIA: We would need a
20 protocol change. And I think that we should --

21 MR. W. JOSEPH TAYLOR: I don't think
22 you can mandate it.

23 MR. BROEDEL: Well, it would be like

1 an IO. If we make the protocol, it would have to
2 meet the protocol. Doc, how many trial patients come
3 in a year?

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

6 MR. FITZGERALD: Why are we doing
7 this then? How often does somebody come in with
8 absolutely nothing? It's rare.

9 MR. W. JOSEPH TAYLOR: Almost never.

10 DR. DETRAGLIA: Should we study it?
11 I mean it's time. We should be able to do it in a
12 couple of months.

13 MR. FARAONE: We have IV failures on
14 routine calls, but a lot of those are just basically
15 you don't look good, you don't really need it. I'm
16 not going to do it. In a code situation I think
17 probably -- I don't know.

18 MR. BROEDEL: Maybe we should study
19 this for a couple of months.

20 MR. FITZGERALD: You can even pull
21 the PCRs for the last twelve months.

22 MR. W. JOSEPH TAYLOR: Actually it's
23 on the CQI sheets for cardiac arrest.

1 (WHEREUPON, all Members were
2 interjecting one another.)

3 DR. DETRAGLIA: We can pull out the
4 trauma center data. And I never -- I can't remember
5 that ever being an issue. Well, let's look at it.
6 If we find we have a problem with it, then we can
7 extend it to adults. As to QuikClot we're going to
8 request -- we have requested that the company enter
9 us into a trial. We will assign the item to five
10 respective agencies. We have to get at least three
11 cases from each agency. And I'll ask this guy the
12 lead investigator in these papers what statistically
13 we would need. And the company is going to be happy
14 to do this because they're looking for clinical data.

15 MR. W. JOSEPH TAYLOR: I guess that's
16 fine. I just don't think you're going to get a lot
17 of data. My experience is that a lot of -- ninety
18 percent is blood trauma as opposed to --

19 MR. FARAONE: Well, he gave you the
20 numbers. What were they?

21 DR. DETRAGLIA: Ten percent.
22 Actually less than ten percent is penetrating.

23 MR. W. JOSEPH TAYLOR: And usually

1 it's penetrating trauma. I mean how many of these
2 are going to be open wounds that you think you're
3 going to use that?

4 DR. DETRAGLIA: Hey, you know, the
5 point is -- I don't think it's very expensive or very
6 inexpensive. It may work appropriately. What we
7 don't want is somebody putting an eight dollar piece
8 of technology on a wound that required a bandage.
9 That's my concern. It may not be a legitimate
10 concern, but that's why I want to look at it if we
11 can.

12 MR. HOFFMAN: Or will be if it's
13 going to be over the counter.

14 DR. DETRAGLIA: If it's over the
15 counter, then every ambulance agency has got to make
16 a decision.

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

19 MR. BROEDEL: As I was picking up I
20 noticed one more thing and that's the trauma
21 conference on June 1st has a request for med hours.
22 Last year we provided three hours of basic and two
23 hours of advanced. They signed the program.

1 MR. FARAONE: There was three plus
2 two so it's five hours.

3 MR. BROEDEL: That's five hours of
4 continuing ed, right?

5 MR. FARAONE: It has to be more than
6 two hours.

7 MR. BROEDEL: Of ALS?

8 MR. FARAONE: Don't you think? It
9 doesn't sound right. Was it an all day program?

10 MR. HOFFMAN: Five hours.

11 MR. BROEDEL: Yeah.

12 MR. FARAONE: Then they should get
13 five hours of category one.

14 DR. DETRAGLIA: I would think. Why
15 didn't we not -- oh, I know, the docs are split up
16 between talks for docs and EMS. And it's a three
17 two, two three. But I think we should get everybody
18 together. If you listen to the doc talk about burns,
19 it may not all be applicable, but most of it will.
20 And we can try to tell the docs to emphasize
21 pre-hospital and non-medical personal.

22 MR. BROEDEL: I think we ought to
23 make it five hours.

1 MR. FARAONE: And the other thing
2 too, remember, it's a moot point this year because
3 all of our providers are done for the year.

4 MR. BROEDEL: No, they'll need this
5 for the pilot.

6 MR. FARAONE: Okay.

7 MR. W. JOSEPH TAYLOR: Was that the
8 final decision for 2007? All the hours are satisfied
9 based upon the updates?

10 MR. HOFFMAN: Right.

11 DR. DETRAGLIA: Correct. I think it
12 should go hour for hour.

13 MR. BROEDEL: Okay. That's what
14 we'll do. Thank you.

15 DR. DETRAGLIA: We're adjourned.
16 Thank you for your time.

17 (WHEREUPON, the Meeting was
18 concluded.)

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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: March 23rd, 2007

Cynthia Belmonte

