1. A "snow hurricane" predicted to hit during this month's SEMSCO meetings prompted hasty compression of the two day schedule into one. This further reduced the already light 2010 SEMSCO schedule and made for a very long and tiring day. When you read about the Niagara Falls CON appeal, you'll feel some SEMSCO pain. Some committees were unable to meet but will conduct their business electronically or by telepathy.
2. Vital Signs 2010 hits the calendar a bit earlier than previous years, and will land in New York City for the first time ever. The educational program and conference brochure will shortly be posted on line. If you're expecting a package with the entire program to arrive by snail mail, fuhgeddaboudit…all you'll get this year is an itty bitty postcard referring you to the web site. Check www.vitalsignsconference.com for details on the August 26 – 29, 2010 conference to be held at the New York City Sheraton Hotel and Towers.
3. EMS Week is May 16 – 23, 2010. The EMS Memorial service will be held starting at noon at the Empire State Plaza in smAlbany on Wednesday, May 19th. Three names will be added to the Memorial: Mark B. Vincent (Cape Vincent Volunteer FD), Louis J. Flury (Union Fire Company), and Richard F. Quigley (Hudson Valley Paramedic Service). Agencies interested in sending ambulances or emergency vehicles should contact Donna Johnson at DOH (phone 518-402-0996, extension 3). All are encouraged to participate in this memorial to pay respect to our EMS brothers who made the ultimate sacrifice.
4. First there were none, now there are many. Yes, PCRs arrived at Regional Program Agencies by the pallet during January. No need to ration your supplies at the moment. Not quite sure if the state was able to replenish their supplies of death certificates, but that's not our problem, directly. Keep in mind, however, that the PCR supply is not infinitesimal...shortages may occur again. Failing to plan is planning to fail. And if you have not thought about migrating to electronic PCRs, you are far behind the times. Wake up and smell the coffee.
5. Several new Policy Statements are up on the Bureau website. They cover such topics as epi and defib requirements, distributive learning and vehicle inspections. Click to www.health.state.ny.us/nysdoh/ems/policy/policy.htm.
6. Give some thought to nominating a colleague for a 2010 NYS EMS Award. Submissions are due at DOH by June 1st and must first be vetted by your Regional Council. A new award category, "Youth Provider of the Year," will recognize a 14 to 18 year-old nominee. Nomination forms are at www.health.state.ny.us/nysdoh/ems/emsawards.htm.
7. Jeepers! Nearly every top FDNY*EMS official filed into the Medical Standards meeting including Chief Medical Officer Dr. David Prezant, and EMS Medical Directors Drs. Dario Gonzalez, John Freese, and Brad Kaufman along with EMS Chief John Peruggia and Assistant Chief John McFarland (check the video if you must see for yourself: www.health.state.ny.us/events/webcasts/). The meeting opened with a chilling report on therapeutic hypothermia in the Buffalo and Albany regions (pun intended). This was immediately followed by a pounce and all out assault on a NYC field triage scheme originally proposed last December. NYC proposed modifying START triage adding an Orange category between the Red and Yellow. It was earlier kyboshed over concerns of interoperability with mutual aid into and out of NYC. During the lengthy banter (i.e., discussion), questions were also raised about the SMART triage system in use throughout the rest of NYS which apparently has little to no evidence basis supporting it (but whudda thunk that?). During several moments when the oxygen level in the room must have been precariously deficient, it was suggested that the FDNY proposal be adopted statewide to

avoid interoperability concerns. Ultimately, the proposed FDNY triage system was approved. For NYC only. Keep this tactic on file for the future: if you find yourself facing a trouncing at SEMAC, empty your administrative offices into the meeting room!

8. In other business, both Medical Standards and SEMAC approved a prehospital hypothermia study proposed by NYC. Dr. John Freese (yes, we see the irony) presented data from Phase I of a NYC study where out of hospital cardiac arrests with ROSC (Return of Spontaneous Circulation) were taken to hospitals capable of TH (Therapeutic Hypothermia). Between 1/5/2009 and 2/24/2010, NYC EMS reversed 2,097 out-of-hospital cardiac arrests. Interestingly, the incidence of VF as a presenting rhythm declined from 25% in 2008 to 18% in 2009 (following national trends that seemingly reflect better cardiac care). The number of NYC hospitals offering TH increased from 37 of 62 to 44 of 60 since the study began. Survival to discharge continues to improve in NYC. Under the proposed (and approved) protocol, medics will begin an infusion of 30 cc's per kilogram of 4°C saline (up to 2 liters total) at the start of each out of hospital resuscitation. It is hoped that the results will boost the present 1:4 survival to discharge rate.
9. St. Vincent's Hospital in Greenwich Village (NYC) may be the next victim of hard economic times. Having emerged from their first bankruptcy some 700 million dollars in debt, the hospital once again appears to be taking on water and may be forced to close by the end of February when a state bailout dries up. St. Vinny's, the only remaining Catholic Hospital in NYC, serves a predominantly lower income population, operates multiple clinics, a trauma center and very large Emergency Department, multiple 911 ambulances and a paramedic training program. DOH is examining how closure might impact EMS in the City.
10. Dying to know what's going on with the new curriculums? Follow this link to the source: www.nasemso.org/EMSEducationImplementationPlanning/index.asp. If you click on the Toolkit link and then scroll down to Transition Materials, you'll be in the secret squirrel section being used by the rocket scientists (well, not really but that sounded impressive) writing new course objectives. The scheduled roll out in NY remains set for Sept. 2011.
11. SEMAC phone conferenced with officials from the VA to discuss triage and transport concerns. Some vets adamantly refuse transport to specialty centers (trauma, stroke, cardiac) because their coverage requires them to seek care only at VA Medical Centers. Well, it turns out that the VA Health Care system is more robust than anyone knew. Excepting trauma, most VA Medical Centers have stroke, cardiac, and other specialty capability that rivals designated specialty centers. Discussions will continue on creating effective triage and transport policies that assure equal access to quality specialty and trauma care for veterans. Stay tuned. Heck, for all we know, VA might be holding out on us. Maybe they have super secret special healing powers? Stay tuned…
12. Training and Education proposed (and SEMSCO accepted) a requirement for a lesson plan approved by an agency (or regional) medical director and CIC whenever a skill or device is being introduced or taught to certified prehospital providers outside of a NYS EMS Certification Course. At minimum, such a lesson plan must include a terminal objective, cognitive, psychomotor, and affective objectives and written and practical skills evaluation. If your inquiring mind wants to know what the heck this applies to, examples would be roll out of a new cardiac monitor, traction splint, bandage, pulse oximeter, tooth

reimplantation (if you actually reading these notes last time around) or any other doo hickey not covered in original CFR or EMT training.

13. You may recall last year the Bureau issued a Request for Information (RFI) from prospective vendors for development of a statewide electronic PCR reporting platform. Well, using a second year of GTSC (Governor's Traffic Safety Council) grant monies awarded for statewide enhancement of electronic PCRs, the Bureau has awarded a contract to Imagetrend (www.imagetrend.com) to consolidate data dumps from the many different electronic PCR platforms currently in use throughout NYS. Imagetrend will also offer an interface for smaller services to directly enter PCR data into the Statewide database (a sort of "poor man's" ePCR) and will transfer State PCR data to the national NEMSIS database. The vendor will also provide a comprehensive reporting platform accessible to users, regions, counties, DOH and others to analyze PCR data. At least 17 states currently use Imagetrend to consolidate and bridge PCR data. Learn more at www.imagetrend.com/default.cfm?PID=1.3.1. Expect to see this process roll out gradually over the next year.
14. The TAG appointed to examine Mutual Aid issues and definitions has met twice and plans additional meetings and phone conferences (perhaps a couple hundred or more). It's difficult to say where this is going except to note that considerable work is needed. Clarification of the meaning of "mutual aid" versus routine coverage during staffing shortages, as well as the terms reciprocal, occasional, repetitious, and predictable seem to be high on the "to do" list. A poignant letter from the Ogdensburg Volunteer Rescue Squad to the Bureau provided a neat snapshot of the issues at hand. Solutions, however, do not appear immediately evident. Keep an ear out for reports from this TAG.
15. Over a year from its filing, an appeal by the City of Utica remains in the Bureau of Adjudication awaiting issuance of ALJ (Administrative Law Judge) findings. The DOH EMS folks met with the Chief Administrative Law Judge who expressed surprise at the prolonged time(s) his office has taken to provide ALJ opinions on SEMSCO appeals. To help track workflow, DOH will provide a "suggested" timeline for return of ALJ opinions with each future appeal. Perhaps a cupcake with a one year birthday candle would help move the Utica Appeal along…
16. The North Area Volunteer Ambulance Corps (NAVAC) appeal actually made it out of the ALJs office! NAVAC had appealed the denial of a Central NY REMSCO decision not to issue an expansion of operating territory. The ALJ indicated several procedural errors in the REMSCO process and, in a meeting with the REMSCO and appellants, the SEMSCO Systems Committee was able to reach a mutually agreeable decision granting some (but not all) of the originally requested expanded operating territory. SEMSCO agreed with the recommendation of the Systems Committee. Case closed.
17. Here's a legal term: de novo. Ever heard of it? If not, it refers to a standard of review that allows an appeals court to substitute its own judgment about whether SEMSCO correctly applied the law and regulations in reaching their decision. A court challenge to a SEMSCO decision denying a Niagara Falls Memorial Hospital CON on the grounds that no public need was established landed back in the lap of SEMSCO on several counts, using de novo review. The digest version of this story is that Niagara Falls Memorial Hospital filed a CON in 2008 with Big Lakes Regional EMS Council to operate an interfacility transport ambulance. Big Lakes supported the issuance of a CON which was promptly appealed by a local ambulance service on the grounds that there were at least

two existing ambulance services willing and able to provide the interfacility transport service the hospital claimed was not elsewhere available. SEMSCO voted previously (by a margin of 12-11), based on absence of demonstrated public need and the applicant statement of purpose being cost savings, to deny the Niagara Falls Memorial Hospital CON. The hospital filed suit in State Supreme Court, alleging that SEMSCO failed to properly evaluate the appeal. The court agreed and sent the appeal back for reconsideration. The systems committee recommended once again to deny the Niagara Falls CON. The term "de novo" was important to the very lengthy (did I mention incredibly long, drawn out, and time consuming?) discussion at SEMSCO as the remand from the court required SEMSCO to reconsider their decision without use of any new information. By a vote of 15-10 (with 1 abstention), SEMSCO again denied the Niagara Falls CON.

18. The Safety TAG and Medical Standards poured over a grid of skills and procedures done in the back of a moving ambulance by unbelted EMS providers (incredibly, they still had time and energy to actually do this after pounding on FDNY for a couple hours). Bottom line, this grid will eventually come out as a SEMAC Advisory, but for the benefit of all you anxious folks who can't wait another second to get your hands on it, here is a rough approximation of the grid as it stands. There may be a third class added to include skills that could be performed with caution in a moving ambulance only if absolutely necessary for the patient.

Class I Interventions – Skills that should always be performed even if the provider cannot be restrained properly in a moving vehicle. The provider should restrain themselves immediately upon completing the skill. If practical, the vehicle should stop. The driver should be aware that providers are unrestrained:

Management of Obstructed Airway	Hemorrhage control
Use of Automatic Ventilators	Auto-injectors
BLS Airway Skills (NPA, OPA, BVM, Suction, etc)	CPAP/BiPAP/PEEP
Carotid Massage	Medication or fluid administration (without sharps)
Chest tube monitoring	Oxygen therapy
CPR or Mechanical CPR device (regions should consider protocols to reduce futile transports)	Patient monitoring (SpO_2, EKG, $EtCO_2$, art lines…)
Pacing (external or transvenous)	BG testing

Class II Interventions – Skills that should not be performed in a moving vehicle because of risk for harm to patient or lack of clear benefit. Stop the vehicle to perform these skills:

Advanced Airway Skills	Gastric Decompression
Chest Decompression/Chest Tube Placement	Detailed Physical Exam
Cricoid Pressure (Sellick)	Blood/Blood Product administration
Defibrillation/Cardioversion	Central/Arterial Line placement or use
Splinting and Immobilization	IM Medication Administration - not auto injector
Venous Blood Sampling – Obtaining	Rectal Medication Administration
Urinary Catheterization	Subcutaneous Medication Administration
Assisted Delivery (Childbirth)	Thrombolytic Therapy – Initiation
Blood Pressure Monitoring	12 Lead EKG acquisition
IV/IO placement (if immediate transport required, perform enroute with provider restrained as able)	

19. Included in the Governor's Budget Proposal, the Office of Homeland Security, State Emergency Management Office, the State 911 Board, the Office of Cyber Security and Critical Infrastructure Coordination and the Office of Fire Prevention and Control will

merge into a single State agency, (the Division of Homeland Security and Emergency Services), to provide greater support to local first-responders, improve coordination of a wide array of State and Federal grant programs, and advance the vision of a county-driven statewide communication network, theoretically delivering efficiency savings of $1.5 million annually. In addition, the consolidated agency will award new grants from the cellular surcharge to county consortiums to assist in the development of regional interoperable communication networks for use by both state and local first responder agencies. Sounds pretty lofty. As an FYI, the DOH opposes this consolidation.

20. Closer to home, the State Hospital Review and Planning Commission (affectionately known as SHRAPC) is scheduled to merge with the Public Health Council under the Governor's proposed budget. While these acronyms may be gobbledygook to you, these are HUGE advisory councils. Their proposed merger is very clear writing on the wall: downsizing. Could some of the other 40 plus advisory councils could face consolidation (i.e., SEMSCO, SEMAC, STAC, EMSC)? You betcha.
21. In the category of "ha ha, beat ya to it," SEMAC's letter to the NYS Cardiac Advisory Committee (CAC) requesting a separate risk-adjusted reporting category for ROSC patients taken to the cath lab crossed in the mail with a return "been there, done that" letter. While the proposed criteria to exclude certain patients from risk adjusted, public report cards that rank cardiologists (and heart surgeons) was not everything SEMAC wanted on their birthday cake, it seemed a reasonable start to addressing the underlying issue: post cardiac arrest patients getting appropriate care without fear of damaging a hospital or cardiologists reputation in the process. We'll see if the change makes a difference.
22. Ryan White is back. In federal law, that is. A little bird tells us (actually, it was Lee Burns) that the Bureau has developed some interim guidance to assist agencies with source patient testing questions and concerns. Keep an eye on the Bureau's page: www.health.state.ny.us/nysdoh/ems/aids/occupational_exposure/index.htm. And watch for news here. Word has it that legislation may be passed this session resolving some of the key issues emergency services continue to face with source patient testing (that did come from a little bird).
23. Got ketamine? Not yet (unless you moonlight breaking into veterinary clinics at night). Both BEMS and the BNE (Bureau of Narcotic Enforcement) folks have provided position statements to DOH favoring approval of ketamine for prehospital use. No word yet on whether it will get the nod.
24. Of the three total SEMAC and SEMSCO meetings in 2010, two remain: Tuesday and Wednesday, May 25 and 26; and Tuesday and Wednesday, October 5 and 6. Meetings are at the Crowne Plaza Hotel, State & Lodge Streets in Albany, NY 12207.

These notes respectfully prepared by Mike McEvoy who previously represented the NYS Association of Fire Chiefs on SEMSCO before (finally) being replaced by Mike Murphy. Contact Mike at McEvoyMike@aol.com or visit www.mikemcevoy.com. If you want a personal copy of these "unofficial" SEMSCO minutes delivered directly to your email account, surf to the Saratoga County EMS Council at www.saratogaems.org and click on the "NYS EMS News" tab (at the top of the page – or you can simply click here to be taken directly to the source: www.saratogaems.org/NYS_EMS_Council.htm). There, you'll find a list server dedicated exclusively to circulating these notes. Past copies of NYS EMS News are parked there as well.