State Council Report
May 13 & 14, 2015

Staff Report

The new blood regulations have come down from the comment period, they are currently under final review by the division of legal affairs and almost ready to go to the commissioner, the bureau is ready to go with all forms and training materials once it signed. Speaking of the Commissioner, Commissioner Howard Zucker has finally been confirmed as commissioner.

The Bureau is still waiting to see what their cash ceiling is going to be for 2015, and that new contracts for the program agencies are in the works.

The Vital Sign’s conference will be held in Syracuse this year and will be held on October 22nd – 25th.

Part 800 revisions are in final draft, the bureau seems very pleased, they define and clarify things so much better as well as codifying training. An electronic copy is available if anyone would like to see them I can forward them via email.

Due to some CON issues across the state the DOH pulled every agency’s file to compare their operating territory over the years, they found only 42 services with minor issues and only 9 agencies that there were territory issues that need to be resolved.

The trauma verification process is going very well, there are 7 newly verified centers with 15 applications still pending. Westchester Medical Center is now a Level 1 Trauma center for adults and pediatrics.

There are apparently Narcan Nasal Injectors on the market and being advertised, however, these devices have not been approved by the FDA.

Lee reported that in 2014 that 2.5 – 3 million PCR’s were submitted electronically, even though there are only 462 that submit electronically it makes up about 90% of all PCR submissions.

The Department of Health has printed little fold up cards for a head/Brain injury, they will be dispersed to all agencies around the state to hand out to patients.

The Part 80 Regulations have been drafted requiring all ALS agencies to have to carry narcotics. The bureau is not really sure how long it will take to get these regulation changes adopted.
**Medical Standards/ SEMAC**

The western NY ALS protocols were approved, however this led to a discussion about the use of diastat rectally. Apparently the use of all rectal administration was removed from allowed practices a few ago, there was much discussion amongst the doctor’s on whether or not it should be put back in the protocols, while all of the physicians agreed that there are better medications and way to administer them out there it was decided in a 9-6 vote to allow the rectal administration as a last resort.

FDNY Hatzac protocols were approved.

The new Spinal immobilization protocol was quite the interesting topic, the TAG that has worked on this wants this new protocol to be adopted and rolled out ASAP, they all but stated that backboards are actually harming our patients. While the protocol is approved the bureau will not give exact dates on when it can be rolled out. The concerns are that we have to put training materials together to train existing EMT’s, new EMT’s and most importantly emergency department nurses and doctor’s so that they are not biting the heads off of EMT’s bringing the non-boarded patient in. The main concern is how to get this in the EMT curriculum, EMT tests, and the PSE’s. The bureau has promised that this should be completed by the SEMAC meeting.

Keep an eye out for the new CPAP policy statement, curriculum and protocols should be sent out very soon.

There was a report from the bleeding and hemorrhage TAG that was accepted, later in the meeting the new bleeding and hemorrhage control protocol was adopted with some minor changes, the main changes are whether or not we should be assessing the patient in an A,B,C method or in a C,A,B method. Honestly the protocol is more in line of how we already evaluate and treat these injuries as providers. There was a question of it being in a flow chart format and not the normal protocol format, Lee advised that eventually all of the NYS BLS protocols will be in the form of a flow chart.

Dr. Dailey gave a presentation on an Epi Demonstration Project that he would like to have approved. This would allow basic EMT’s to draw up Epi in a syringe and administer that way instead of the Epi-Pen. Did you know that the EMS agencies in NYS alone will throw away 10 million dollars in expired Epi Pens this year?? This pilot project will be in conjunction with the University of Rochester, they will actually build and dispense all of the kits, they will include all of the needed supplies including specially marked syringes for adult and pediatric dosing. Every kit will be numbered and tracked by the university, there will also be a telephone number that the provider must call after administration in which they will speak directly with a physician to review the case and document the data. Any agency in the state can participate and should let the region know. Once the kits become available we will know more.

**Pier**

The NYS EMS provider award nominations are due June 1st, there was discussion because these also get forwarded to the national level, however the nation due date is June 15th, this leaves little time to review the nominations and forward them so effective in 2016 the NYS award nominations will be due by May 1st.

**Education and Training**

Andy Johnson reported that CIC fast track has enrolled 202 people with a total of 85 that have completed the requirements and are now CIC’s.

There are roughly 5300 providers that have taken EMT tests this year to date.
NYS is averaging 15 days to get the results of the exams out from the time of the exam, they are also looking at purchasing printers that can print the cards within the bureau, and this will cut even more time off.

There was a lengthy discussion on the scheduling of BLS protocol and curriculum update roll outs, currently whenever there is an update it is sent out to the instructor’s and regional program agencies, this could happen several times a year. The recommendation is to pick an annual date to roll out all changes to better give instructor’s and provider’s time to prepare for the change. The exception to this would be if an emergency protocol had to be created, that would be rolled out immediately. This recommendation was approved by the SEMSCO however the roll out date has not been set.

There was a brief discussion about the National Registry Paramedic changes, they are reducing the PSE stations from 11 stations to 6, with all of the other skills being documented on competency forms during the actual class. The question will be is what will NYS do???

The last item of the meeting was where is the EMT –CC level going, it currently doesn’t meet national standards, and the curriculum is out of date and the bureau doesn’t have the resources to update it. As you can imagine this was a pretty intense conversation because there are areas of the state that only have EMT-CC’s to provide ALS care. The committee didn’t make any recommendations at this point however there was some discussion on the SEMSCO putting a TAG together to look at this further, the makeup of the TAG was also discussed with no real direction at this point.

**Systems**

Attached is the operations update from the BEMS, there are no new CON appeals at this time, however the ALJ has issued his report on the one pending. Monroe Ambulance had files an application to expand into eastern Orleans County, due to some issues throughout the regional council process the expansion was never approved, the ALJ has recommended that the SEMSCO grant the expansion, it was voted on and passed.

The CON TAG is still working on their report and is currently looking at several different things as a reference. The goal is to provide more guidelines to regional councils and ensure that they take this CON process more seriously.

Ambulance construction was also a topic, apparently the Chevy chassis is going away, there are not a whole lot of options out there at this point, the sprinter is looking to be one of the best options at this point. The new KKK standards require different stretcher mounting systems as well as some sort of loading system, fortunately NYS does not follow KKK standards, however the NYS regulations are antiquated and need to be revised and updated, the safety committee will be tasked with this project.

**Executive Committee**

Discussion related to article 30 reform, the goal is to consolidate seated bodies as a reduction of cost.

**Finance**

No Report

**Safety**

The final draft for the updated “reportable Incident Form” has completed

Roughly 20% of all the patients we see have some sort of disability, the first responder disability awareness courses that are taking place around the state are highly recommended.

There was also some talk on the safety of the providers and feedback on the excited delirium protocol adopted in the Central New York area with several cases of synthetic marijuana usage.
Legislative

The SEMSCO has endorsed two separate bills

The first is bill A7503 and S5481 – these bills would authorize community paramedicine services be provided by emergency medical providers. Phil was forwarded an email asking for letters from your agency to support this bill.

The second is A1512 and S1055 – This bill would increase the Medicaid reimbursement for ambulance transportation to reach 100% of the Medicare rate over the next three years and exempt transportation to obtain emergency care from the requirement for prior authorization under Medicaid.

Other SEMSCO Business

A pediatric policy statement has been drafted regarding recommended pediatric equipment for certified EMS response vehicles. The draft and list is attached. The biggest focus of this is to ensure that the appropriate size restraint system/seat is in the ambulance, the child should never be transported in the mother’s arms. This policy statement was endorsed by both SEMAC and SEMSCO.

There has been some conversation the Bureau of Narcotic Enforcement regarding the quarterly and bi-annual reporting of narcotics, the goal is to rework the forms and make a standard reporting period.

There is also some conversation about using Ketamine on standing orders for RSI/MFI and Excited Delirium when necessary for patient and or provider safety. Then they spoke about using Fentanyl intra nasal for pediatrics on standing orders. These two were approved by SEMSCO.

The next SEMAC and SEMSCO meeting dates are currently scheduled for September however due to conflicts will most likely be moved to later in the year.

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**WE MUST BE WORSE OFF THAN I THOUGHT. THE MEDICAL ARE SAVVY.**
TO: Mr. Chairman and the Systems Committee  
FROM: BEMS Operations Section  
DATE: May 14, 2015  
SUBJECT: Operations Report

This represents a summary of activities the Operations Unit has been involved with since your last meeting. As you read through this report, please feel free to ask questions.

Regions are reminded to submit CON documents electronically as scanned documents, primarily in PDF format (maps and images submitted by an applicant in a JPG or GIF format may remain in the native format). The Department will not conduct F&C reviews for applications it has not received a full copy of any application submitted to a REMSCO.

The following are CON related actions submitted (or pending where indicated).

- **Appeals to Article 30 actions** – Monroe Ambulance EOT with ALJ Report
- **Municipal CON Declarations under A30 PHL 3008(7)(a)**
  - Town of Lexington (Amb) – Operator will be Town of Ashland Ambulance
  - Town of Prattsville (Amb) – Operator will be Town of Ashland Ambulance
  - Town of Cobleskill (Amb) – Operator will be Village of Cobleskill (?)
  - Town of Pittsfield (Amb) – Operator will be Village of New Berlin
- **Municipal conversions to permanent status (rollovers) completed or in process now**
  - Town of Portland Ambulance Muni Rollover
- **New “Traditional CON” Services**
  - Watchtower Bible and Tract Society of New York, Inc. Ambulance
- **New Services Approved – Federal or Air Services**
  - None
- **Transfers of Operating Authority completed or in process under A30 PHL 3010(2)**
  - Cuylerville Fire Department TOA to Cuylerville Ambulance Service, Inc.
  - Wayland Springwater TOA to NFP
  - CUBRC, Inc. to Avarint, Inc. – Nunc Pro Tunc TOA (ALSFR)
  - Village of Cohocton FD Amb to Town of Cohocton Amb Inc. TOA
  - Lutheran NYU Langone Hospital TOA (corporate restructuring)
  - Medic East II, Inc. to SeniorCare TOA (corporate restructuring - pending)
  - Town of Hancock FD Ambulance to Town of Hancock Ambulance, Inc. TOA
  - DLFE to Darien Lake Ambulance, LLC TOA
  - Capital District Ambulance – Nunc Pro Tunc TOA
  - Doctors Ambulance – Nunc Pro Tunc TOA
- **Stock Transfers Under A30 PHL 3010(2)(c)**
  - Twin City Ambulance Corporation TOS – Owner deceased – Joint apps to Big Lakes & Wyoming Erle Pending – Application pending court probate processing.
- **Expansion of Operating Territory under A30 PHL 3008**
  - Northern Dutchess Paramedics EOT for Town of Dover
Operating Certificate Surrenders

- Crown Point Fire Department
- Mid County Volunteer Ambulance Service, Inc.
- Oppenheim Volunteer Fire Company, Inc. – Downgraded from ALSFR to BLSFR
- Stat EMS LLC – Service not operating last 13 mo per company president
- Chester Volunteer Ambulance Corp., Inc. – Service no longer operating

Other BLSFR Services Recognized by DOH:

- BLSFR EMS Agency ID#’s issued
  - Vassar College Emergency Medical Team
  - Rosendale Police Department
  - Oppenheim Volunteer Fire Company (surrendered ALSFR & downgraded)
  - Lawrenceville Fire Department
  - Collins Volunteer Fire Company

Other Items:

- BEMSATS Operations Review of Records to Verify Certified Service Territories
- Updated Status of Intermediate Level Certified Services (see attached lists)
- #06-06 Policy Revisions TAG
- Policy for Pediatric Equipment on Certified Vehicles (see attached Policy)
EMS providers care for patients of all ages, who present with a wide variety of illnesses or injuries. Nationally and in New York State 9-10% of all EMS responses are for pediatric patients; in New York that amounts to approximately 270,000-300,000 pediatric patients annually are treated by EMS. In an effort to better care for pediatric patients, the federal Emergency Medical Services for Children (EMSC), in collaboration with the American College of Surgeons Committee on Trauma (ACS-COT), American College of Emergency Physicians (ACEP), National Association of EMS Physicians (NAEMSP), American Academy of Pediatrics (AAP), Emergency Nurses Association (ENA), and the National Association of State EMS Officials (NASEMSO) have jointly developed a list of standardized equipment for emergency ground ambulances. All four seven organizations adhere to the principle that Emergency Medical Services (EMS) providers at all levels must have the appropriate equipment and supplies to optimize prehospital delivery of care.

This recently updated list of Equipment for Ground Ambulances (2014) has been approved and endorsed by New York’s State EMS Council (SEMSCO), State Emergency Medical Advisory Committee (SEMAC) and the EMS for Children Advisory Committee (EMSCAC) for certified EMS agencies in New York.

Equipment for Ground Ambulances Online Version:
(Publisher Name: American Academy of Pediatrics & Journal of Prehospital Care).
This link references the complete document/equipment list for both BLS and ALS ambulances.

Below is a chart of pediatric BLS items required in New York State Part 800 regulations and also includes the national Equipment for Ground Ambulances recommendations. You will notice adult sized equipment is included with pediatric sizes as many children are the size of small adults. While NY regulations are being reviewed and amended, the additional recommended equipment to current Part 800 regulations are the shaded items. New York State does not regulate ALS equipment at a statewide level. However, NY’s SEMSCO and SEMAC recommend Regional Medical Advisory Committees (REMAC) should consult the national Equipment for Ground Ambulances list when updating the regional ALS equipment requirements.
<table>
<thead>
<tr>
<th>BLS Equipment</th>
<th># Pieces of Equipment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suction catheters</td>
<td></td>
</tr>
<tr>
<td>Rigid tonsil tip</td>
<td>2</td>
</tr>
<tr>
<td>Flexible between 6-10 French</td>
<td>2 each</td>
</tr>
<tr>
<td>*Flexible between 12-16 French</td>
<td>1</td>
</tr>
<tr>
<td>Oxygen delivery</td>
<td></td>
</tr>
<tr>
<td>Nasal cannula- Adult</td>
<td>4</td>
</tr>
<tr>
<td>Nasal cannula- Child</td>
<td>2</td>
</tr>
<tr>
<td>Non-rebreather masks- Adult</td>
<td>4</td>
</tr>
<tr>
<td>Non-rebreather masks- Child</td>
<td>2</td>
</tr>
<tr>
<td>Bag valve mask</td>
<td></td>
</tr>
<tr>
<td>Hand operated self-expanding bags child 450-750 ml</td>
<td>1</td>
</tr>
<tr>
<td>Hand operated self-expanding bags adult &gt;1000 ml</td>
<td>1</td>
</tr>
<tr>
<td>Masks for BVM</td>
<td></td>
</tr>
<tr>
<td>Adult</td>
<td>1</td>
</tr>
<tr>
<td>Child</td>
<td>1</td>
</tr>
<tr>
<td>Infant</td>
<td>1</td>
</tr>
<tr>
<td>*Neonate</td>
<td>1</td>
</tr>
<tr>
<td>Airways</td>
<td></td>
</tr>
<tr>
<td>*Nasal Airways 1 size between 16-24 fr</td>
<td>1</td>
</tr>
<tr>
<td>*Nasal Airways 1 size between 26-34 fr</td>
<td>1</td>
</tr>
<tr>
<td>Oral airways size 0-1</td>
<td>2</td>
</tr>
<tr>
<td>Oral airways size 2-3</td>
<td>2</td>
</tr>
<tr>
<td>Oral airways size 4-5</td>
<td>4</td>
</tr>
<tr>
<td>*Pulse oximeter</td>
<td>1</td>
</tr>
<tr>
<td>*with pediatric probe</td>
<td>1</td>
</tr>
<tr>
<td>*with adult probe</td>
<td>1</td>
</tr>
<tr>
<td>*AED that includes pediatric capability</td>
<td>1</td>
</tr>
<tr>
<td>*adult pads</td>
<td>1</td>
</tr>
<tr>
<td>*child pads or dose attenuator with adult pads</td>
<td>1</td>
</tr>
<tr>
<td>Immobilization devices</td>
<td></td>
</tr>
<tr>
<td>Rigid cervical collar - small</td>
<td>1</td>
</tr>
<tr>
<td>Rigid cervical collar - medium</td>
<td>1</td>
</tr>
<tr>
<td>Rigid cervical collar - large</td>
<td>1</td>
</tr>
<tr>
<td>Lower extremity traction - adult</td>
<td>1</td>
</tr>
<tr>
<td>Extremity immobilization small</td>
<td>1</td>
</tr>
<tr>
<td>Extremity immobilization - medium</td>
<td>2</td>
</tr>
<tr>
<td>Extremity immobilization - large</td>
<td>2</td>
</tr>
<tr>
<td>OB Sterile Kit (Commercial or locally packed)</td>
<td>1</td>
</tr>
<tr>
<td>Receiving blanket</td>
<td>1</td>
</tr>
<tr>
<td>*Head cover</td>
<td>1</td>
</tr>
<tr>
<td>Bulb Suction for Infants</td>
<td>1</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td></td>
</tr>
<tr>
<td>Sphygmomanometer adult cuff</td>
<td>1</td>
</tr>
<tr>
<td>Sphygmomanometer pediatric cuff</td>
<td>1</td>
</tr>
<tr>
<td>*Length-based resuscitation tape or reference material that provides appropriate guidance based on length or age</td>
<td>1</td>
</tr>
<tr>
<td>*Age/size appropriate restraint systems for all passengers and patients transporting in ground ambulances. (For children, this should be according to the National Highway Traffic Administration's document; Safe Transport of Children in Emergency Ground Ambulances)</td>
<td>Various</td>
</tr>
<tr>
<td>*Access to pediatric and adult patient care protocols</td>
<td>1</td>
</tr>
</tbody>
</table>

*Shading indicates recommended equipment in addition to Part 800.
**Check & Inject NY**
Syringe Epinephrine Kit for BLS Providers

Thank you to the King County Washington Department of Public Health EMS Bureau for their assistance and guidance.

DRAFT – DO NOT format or use tabs to move text...content only. Use placeholders for all pictures or videos.

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**Objectives**

- Why the program?
- Anaphylaxis review
- Epinephrine use review
- How to use a syringe
- Giving an injection safely
- Disposing of a syringe safely

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**Brief overview of syringe epi**

- King County WA piloted the “check and inject”
  - Hundreds of BLS implementations
  - No injuries to providers
  - No failures to treat patients
    (some increase in treatment)
- Other states doing this include:
  - Montana, Alaska, Florida, West Virginia and others

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**Bottom line**

- Basic life support providers can give intramuscular epinephrine safely
- Why not autoinjectors?
  - Expense: $500-1000/ambulance and going up in price every year
  - Potential injury to providers
  - Rarely used
  - Potential to save the EMS system millions while maintaining ability to treat patients
Plan for the program

- Vodcast of key portions of the training — standardized training
- Pre and post-testing of all participants
- Focused hands-on training as part of a “train the trainer”
- Demonstrate the “6 Rs” as well as the “check and inject” checklist
- Physician review of each case immediately after completion