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HUDSON VALLEY REGIONAL EMERGENCY

MEDICAL ADVISORY COMMITTEE

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MINUTES OF MEETING, held at the offices of Hudson Valley Regional EMS, 103 Executive Drive, New Windsor, New York, on Monday, January 6, 2014, at 9:30 a.m.

Yvette Arnold,

Court Reporter

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A P P E A R A N C E S :

DR. PAMELA MURPHY, Committee Chair

DR. ERIC STUTT, HVREMSCO Medical Director

GOOD SAMARITAN HOSPITAL

DR. DENNIS MAO,
Director

KINGSTON HOSPITAL

DR. FAREED N. FAREED,
Director

NYACK HOSPITAL

DR. MARK PAPISH,
Director

ORANGE REGIONAL MEDICAL CENTER

DR. SANHITKUL,
Physician Representative

PUTNAM HOSPITAL CENTER

DR. BUTTERFASS,
Physician Representative

SHARON HOSPITAL

DR. RICHARD BENNEK,
Director

WESTCHESTER MEDICAL CENTER

DR. JOHN BERKOWITZ, (Via Telephone)
Physician Representative

ALSO PRESENT

DAVE VIOLANTE

ANDY LaMARCA

RICHARD PARRISH

STEVE ANDERSON

NELSON ANDERSON

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DR. MURPHY: We will bring the meeting to order. Thank you everyone for coming.

What I would like to do is update the list and have names with the hospital faces and representatives. So what I would love to do -- and I have a little background music -- is to go around the room because our Stenographer takes notes on everybody and she doesn't know everybody. So like when we speak and when we enter words into the minutes she likes to have everybody's name and exactly who you are. I'll ask we go around the room -- Dr. Eric Stutt, Dr. Pamela Murphy.

DR. BENNEK: Rich Bennek, Sharon Hospital.

DR. FAREED: Dr. Fareed Fareed, Medical Director Kingston.

DR. PAPISH: Papish, Nyack Hospital.

DR. SANHITKUL: Dr. Sanhitkul, Orange Regional.

DR. BUTTERFASS: Andrew Butterfass, Putnam Hospital.

DR. LARSEN: Erik Larsen, the

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Westchester REMAC representative.

DR. MURPHY: And welcome --

DR. LARSEN: Thank you. I've also -- since I got congratulated -- I'm also now the REMAC Chair for Westchester so --

DR. MURPHY: Oh, I'm very glad about that --

DR. LARSEN: It's going to be hard to fill Nick DeRobertis' shoes because he was really a great person. But, anyway, I'm there and Dr. Berkowitz is helping me out, so that's a great thing.

DR. MURPHY: Excellent.

DR. BERKOWITZ: I'm on the phone too.

DR. LARSEN: I see you there, but I didn't recognize you.

DR. MURPHY: He put your name tag on top of the phone speaker so people know you are there.

DR. BERKOWITZ: Nice. Papish sent me a picture that actually is much better than me, thanks.

DR. MURPHY: We will see how many YouTube hits we get by the end of the

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meeting.

MR. LaMARCA: Use that as proof of attendance.

DR. MURPHY: Well, Erik, I'm really glad. They couldn't have picked a person with more experience and just really knows the area, that's the most important thing I think with these jobs. You are just so easy so work with and I'm just really you are in there, so it's great. I'm glad. Congratulations.

DR. MAO: Dennis Mao, Good Samaritan.

MR. ANDERSON: Steve Anderson, Air Methods --

MR. MACHADO: Nelson Machado, Rockland Mobile Care.

MR. PARRISH: Rich Parrish, Vice-President of this organization -- whatever it is -- and the Ulster County EMS Coordinator.

MR. LaMARCA: Andy LaMarca, Director of Mobile Life Support and all --

MR. VIOLANTE: Dave Violante, Arlington Fire District and Chair of Training and

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Education.

MR. HUGHES: Bill Hughes, Executive Director of Hudson Valley Regional EMS Council.

MR. KNOBLOCH: Israel Knobloch, Kiryas Joel.

DR. MURPHY: First and foremost, as everyone, you know, realizes it's been a while since we have been here, a lot has happened in-between, you know, so we are going to, you know, have a pretty extensive agenda today.

The review of the minutes from November, was everybody able to look at them? Anybody able to look at them to move them forward and accept?

DR. BENNEK: I'll move.

DR. MURPHY: Motion to accept the minutes, so moved by Dr. Bennek.

(Discussion held off the record.)

DR. MURPHY: And can I have a second for the minutes?

DR. PAPISH: Second.

DR. MURPHY: Dr. Papish, great. So we

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will accept the minutes as typed, as submitted.

In terms of moving forward, old business. We will start with the easy stuff first.

Medication shortages. Already we are having problems, people getting the Fentanyl that is required for our new protocols. And we also had problems with people getting the ODT Zofran. So you know, two of the drugs that we moved into that column of being able to use -- oh, yeah -- and also the benzos are a problem. So, again, I think what we are going to have to do -- poor Bill sent me an e-mail in panic mode. I'm like what can we do? If the medications are not available we will have to use alternative medicines for right now. We will have to allow people a little more time to get the Fentanyl on board. The way it stands right now the protocols started January 1st, but we gave everybody to the 15th really, a leeway, a time to grade up and get everything on board, but it may not happen because people cannot

acquire the Fentanyl. So what we will have to do is just use the morphine and such for now as a bridging device until we get everything up and running. You know, all said plans are made in stone and sometimes they just don't work. You know, so we are trying. And, you know, we thought that would be a great thing and things would be done. But we even heard from the Department of Health that it's an issue for everybody to get the Fentanyl.

DR. STUTT: We even addressed this some 10 to 12 months ago with Andy Johnson from the State. And we have a written document from him telling us if you do not have the required medication in the protocols you may -- because it's not available, not because you failed to stock it, but because it's not available -- there is no fault to the paramedic or agency for not using that medication at that time and proceed as best you can without that or using alternatives, as Pam said.

DR. MURPHY: Yeah, we really wanted an

opinion from a legal perspective what the thought process was and that's what Eric is citing. You know, it's what we have to do, there is no way around it.

DR. STUTT: That won't impact anybody getting started in the rollouts and getting everybody started by the 15th.

DR. MURPHY: So update on the collaborative protocols and rollouts.

We had rollouts done around the region where pretty much we had a pretty good turn out. We still were missing a few people, but really it was better than I expected. In terms of the paperwork and everything coming back from the agencies, we are behind in that.

What is the number so far?

DR. STUTT: Of the fifteen hospitals, five have completed all their paperwork to us, ten have not given us any comment on who you have in-service and who is up-to-date. Those hospitals that are updated are Good Sam, Putnam, St. Anthony's, Vassar, and Northern Dutchess have provided all their

providers who are up-to-date on that.

In terms of agencies, Karen tells us that almost every agency has provided all their primary and secondary affiliations, as well as the vast majority of providers, the paramedics and critical cares are trained and tested and have passed. There are still a few outliers, they have until January 15th, the date everybody must go live with protocols, to complete all their data and be approved, otherwise they will be suspended and have to retake the protocol exam. And Karen will follow-up with all of them so everybody knows who has to complete their data input for us.

DR. MURPHY: Okay, medical control credentials update.

We -- I cannot take any credit for it -- these guys worked so hard. All of the side manuals were redone, the medical control, the administrative material was all redone, education, training, so part of that whole rollout process has, you know, that information in there. As a medical control

facility we just want to make sure everybody is on-line and knows exactly what they are responsible for. And those -- that's what is important on that DVD that you received to make sure that you review all that material and understand exactly what your responsibilities are as a medical control institution.

First and foremost, we have a great representation here today. Thank you for coming. I know schedules are hard, sometimes you have to call in and that's okay. I think in the future we will try and be more creative. Rich and I were just talking about it before, can we do a go to meeting kind of forum? The problem is they still want it to be videotaped and ability for it to go on the TV that people can watch and everybody have access. So I was saying maybe I could sit here and we could do a go to meeting and we just have computers for everybody. I think people would get pretty bored with me right away. We will cross that bridge, I mean that's where things are going, that's the

advent, meetings are tough to get to physically so we are going to have to think of some creative ways to do that. And, you know, going forward we need to have the participation and really it's the dissemination of information we have to have the stuff filter down to all the docs on the line, they need to know how important this stuff is about medical control --

MR. LaMARCA: I think -- the only thing I think one of the things that held us up of going to a go to meeting sort of scenario is the statutory authority of the REMAC and that a vote would not be legal. So I think it might work for nonstatutory matters, but if it's something REMAC has to vote on, we had have a problem.

DR. MURPHY: Yeah. I think someday it will have to change, someway they can modify so it can occur, but right now there is nothing I can do. We have to still stay in a physical meeting.

MR. LaMARCA: I think they have had some discussion about that for these Article 30

changes because they are talking about making potentially larger regions and more travel time so I think it's something they considered.

DR. MURPHY: They have it also problematic on the State level. As you know what they do is send us out the agenda for the State meeting and they are like, are you going to come? And we have to sign in blood because they won't have a quorum unless the people they say are coming, she counts the numbers and makes sure that everyone is there. So it's a real issue, you know, statewide, it's not just us in the region.

But I appreciate everybody's travel time and how hard it is to get here.

Did you want to add something to the medical control update?

DR. STUTT: No.

DR. MURPHY: So next on the list, even though we are just rolling out to protocols, is we are going to meet and I'm meeting with the other directors from the other regions for suggestions for modifying the protocols

even though we just roll them out you have to keep up to snuff and, you know, continue because things change.

And I think -- did -- Andy, did we hand these out or --

MR. LaMARCA: No. I think Karen might have.

DR. MURPHY: I'm going to pass this around. If you guys need you can take the references and see what's already come out. Jeremy Cushman, who is one of our regional people upstate in the Monroe Livingston region has already put out an advisory that the REMAC there had decided not to use hypothermia and -- because of the two articles that are attached to this advisory that is coming around. You can research the articles. He has put it on hold for right now. In their region they got together at the REMAC level, discussed it -- I'm not asking for us to discuss it at this point. I want you to be aware that one of the regions in our collaborative model has chosen. I would like you to read the articles. I'm

kind of not going to put it on our agenda for any kind of action yet, it's for more information.

This SEMAC on the 14th of January Dr. Freeze should be presenting from New York City his hypothermia project and that was our main project in this region that we were basing our information on and how good it was doing. We need to see what his follow-up now is and is it going to change in light of this information and articles from around the country.

Andy LaMarca again, Mobile Life?

MR. LaMARCA: With my cynical voice -- every time we had State Council and New York City decides to present something, again, I understand they have a lot of resources, even that project is something we would not be able to replicate throughout 95 percent of the State, there are special units, you know, put in a lot of attention, a lot of money. It's not something that really reflects the day-to-day EMS operations.

I do think this REMAC should weigh in on

this because this now extends into the BLS providers as well. It's something we have to talk about later here, but we don't want a lot going out and buying Igloo coolers, you know, stuffing armpits if it's not to someone's benefit.

This Council four, five years ago our position at that time had been we are not going to really worry about it, even retaining the circulation because the paramedics had enough to do just getting the patient stabilized and getting to the hospital. Right now we will bring our BLS providers back in for some updates as it relates to them being immersed in parts of our protocol, this is one part of it. I think you need a position on it --

DR. MURPHY: Correct. I think what we need to do is make a position on it. I think it has to be tabled to next meeting, I want people to research and decide. You have to go back to your hospital and say you have the equipment, is this what you want to move forward with?

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One of the things behind Cushman's advisory, his cardiologist in the area felt very strongly they didn't want to do it. That was an interesting thing I read there. And that's Rochester, that's not, you know, out in the middle of nowhere. So I think we have to take a look, we have to decide and we as a REMAC will come back. And this is your homework for next meeting is to review the articles. I'll get anything I can from Dr. Freeze out to everyone. But as Andy just said, you know, one of the things I was so excited by with the collaborative protocols was we are going to be in the same protocol from, you know, Westchester up to the Canadian border as we stand now and that's amazing. We are way ahead of the curve. Our group has been able to do this in a relatively straightforward format and it's a way for us to say, you know, we can maybe make a statewide protocol. However, I'm going to couch that with, we always say at these meetings, New York City is a different ball of wax and could they ever fit into a

protocol with the rest of the State? I don't think -- I think it's very different in New York City. We always talk about and joke that, yes, we will all be under statewide protocol except for the one area and what we are talking about is New York City. It's very different, the hospitals are so close, the population so dense, the resources so tremendous, it makes that very difficult.

Just like Andy says, even with hypothermia, the protocol will be able to say -- New York City to respond with an individual vehicle for hypothermia which is something we couldn't do in this area. So it's not going to be apples to apples to compare it with when we look at it, but it's still something we need to -- because it's New York State and also they worked so hard on it we do need to take that information and go forward.

It was interesting when I saw this advisory from Dr. Cushman, I was like, wow, put the brakes on. It's something, again, I'll ask everybody, we will come back next

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meeting and discuss it. I like people to read about things and we will all be --

MR. ANDERSON: The same --

MR. LaMARCA: Just to clarify, our new protocols say if available.

DR. MURPHY: If available, yeah. And it's also if the hospital you are going to has the capability to provide hypothermia --

MR. LaMARCA: That's a bit of our disconnect, maybe we should discuss it here or somewhere else. We have the one hour transport rule, we don't really have a great categorization of the hospitals for specialties, whatever they added over the years, so we couldn't tell you other than stroke center, or STEMI center --

DR. STUTT: We talked about --

DR. MURPHY: The last time --

(Everyone is speaking at once.)

MR. LaMARCA: -- but also we look within the region, but if you start thinking about when we get an order for one hour travel time we could be in a New York City, Albany, Connecticut. From parts of our region one

hour travel takes us well outside of our region so we need not only the categorization we are in, but whatever is contiguous to us.

DR. MURPHY: And also some kind of constraint of taking you out of service and lengths of transport. That's where our region has to decide on this because we are going to be different from other areas, that is one of the things we talked about.

DR. STUTT: It sounds to me like you have an hour to get there, but you should be going to the nearest cardiac center, or stroke center, or trauma center even though it says within an hour. It just makes sense you want to go to the nearest cardiac or trauma center.

MR. LaMARCA: Do I take them to a STEMI center that just does that, or a center that does full cardiac? If I have my choice -- and it's six of one, half dozen of another where I go -- probably the reasonable thing would be take them where they do open heart surgery and the rest -- we don't want to get into the micromanaging, but I think there are

certain parts of our area where it's easier to head south, for instance, and drive further than it is to get up into one of our area hospitals. It's something -- I don't remember, but I think the State used to do that, whatever it was. The chart had eight categorizations, if you remember years ago, and each hospital's rank, but we almost need that sort of charting again so a paramedic or dispatch can say, so and so is approved for therapeutic hypothermia, or cardiac, whatever.

DR. MURPHY: Yes. I think it's a work in progress. And I think, you know, am I going to have an answer for you today? No. But it's something we have to look at.

MR. ANDERSON: Steve Anderson, Air Methods. Similar to what is being discussed, it's very common in the air medical industry, at least in our program, knowing what is at the receiving center is a must to make appropriate determination as to where you are going to head with your patient. We are talking scene calls, not in a facility, but

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the benefit of air medical --

(The speaker cannot be heard.)

MR. ANDERSON: -- and that is the difference between a stroke center that has litics (phonetic) versus a stroke center that has neurosurg is commonly the difference of a 30 minute flight versus say a 30 to 60 minute drive in one direction. We commonly make those decisions on the ground and head to those potentially more distant out-of-state or region hospitals, but for an appropriate level of care in a shorter time period.

DR. MURPHY: I think it's -- all of us are on the same page. We need to have that information and I think, you know, it's been hard at times to garnish from each institution what they have and don't have. And then the State steps in and says this is a STEMI center, this is a stroke center. So it's a bit of a gimesh for me to say it's a work in progress. I'm not going to have all the answers, however we will continue to strife and get those answers.

You know, Andy, like you said, that

chart was pretty -- you know, very helpful, but I think it was so demonstrative for them to keep up and keep track of. I think that's why it fell to the wayside.

MR. LaMARCA: I think it was really state categorization if I remember so -- that was so many years ago --

DR. MURPHY: It was a long time --

MR. LaMARCA: I have to believe maybe in the annals of the Department of Health there --

DR. MURPHY: I'll ask Lee on the 14th. Did you want to say something?

MR. ANDERSON: We as a flight program could potentially -- and I say potentially because I don't know what effort has been taken -- our outreach activities and so forth are to keep the dispatch center constantly up on the very things we are discussing. So when an aircraft lands on a scene and yells they have got a stroke patient our dispatch has a data system to give them the closest facilities so we maybe able to share that with this group.

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DR. STUTT: Helicopter destinations are not under our purview, the ground transport is. I know you folks have different destinations and different protocols that we are not using in the colabs.

MR. ANDERSON: But those destinations exist in the region so we maybe able to provide those capabilities, what is St. Francis doing versus a week ago, what are the capabilities say in the region. We keep those updated. If it's something of interest we could look into possibly sharing that and at least starting the process of what Andy was talking about.

DR. LARSEN: That flowchart exists in the back of our -- you know, basically what our hospital capabilities are, I believe it exists if the back of the helicopter protocols. So it's all gridded out who is a burn center, neonatal. I think it's there I don't know when it's been updated.

DR. MURPHY: Dave?

MR. VIOLANTE: Different discussion, but related to REMAC. When we rolled out the

protocols we had called them ALS protocols, they are actually sort the EMS protocols. And we realized that a lot of BLS providers are giving medication under the purview of REMAC, this group of individuals. And so a lot of agencies have put in applications for BLS glucometry and Epipen, Albuterol that sort of thing. Some of the other areas in the protocols need to be addressed for BLS providers. We talked to Andy Johnson at the State about this and he said, oh, yeah, you got trained BLS providers now. And we were like, oh, good, okay. We will just put the scope out there further.

But something else that came up was now where are those BLS providers -- where do they fall? Who has the purview over them? And we are waiting to hear back from operations at the State as to whether the REMAC now must extend their control over BLS providers as well as the ALS providers we currently do. So that has to be discussion that we should think about as well.

DR. MURPHY: I think we have to wait for

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whatever the State says. However, just so everybody is on the same page, so in the past everything -- we are the REMAC, we are the Regional Medical Advisory Committee that makes the decisions and the ideas and formulates the protocols, the standards, keeps everybody together of what we are going to do in our region, how we are going to deliver care. We do that in on-line and off-line control. On-line meaning they call, I have this patient, I want to give such and such, I'm providing on-line control. But off-line control is those protocols and that's -- these guys can follow the algorithm down to a certain point depending on the level of training, that's off-line control. They are abiding by these protocols to deliver the care to that level.

So what Dave has brought up is the State has allowed in giving purview to BLS to start increasing their level of care. And in their education process, training process, they are talking glucometry, they are now taught administration of -- or being taught

administration of Albuterol nebulization, they are being taught Epipen for anaphylaxis. So there are some areas of overlap here that we have to now say, who is providing the education? In the past BLS never answered -- can I say that in a nice way? Answered to us because it was the basic level of care. However, they have -- they are supposed to have a medical director, every corp. -- can I say every corp. has an active medical director? I'll never state my life on that sentence. However, the very active corps. do. I have quite a few BLS corps. underneath me. So I think we have to talk about reaching out even further and providing education, even in rolling out the protocols there is a part there that we overlap and intervene and intersect BLS providers, so I think it is something that we have to do. And we went back and forth and had a bunch of meetings about this because it was something that we could not do right away because it was hard enough just to rollout all the advanced life support. And we have to -- and

we talked about doing this very quickly of getting together and having some meetings and educational processes to bring everybody on the same page and have BLS up to snuff. Even though they can't do certain things they should know where the BLS material falls and that we integrate this.

MR. VIOLANTE: There is a bunch of other things too like administrative of nasal Narcan coming down the line --

DR. MURPHY: Yeah, that's from the State again --

MR. VIOLANTE: -- CPAP --

DR. MURPHY: Yeah, CPAP.

MR. VIOLANTE: -- epinephrine for acute asthma. They have to call medical control -- this is under the purview of the REMAC the State said and these corps. also have to give the REMAC sata of them even doing it, which is not always there. We want to reach out educationally and be progressive and try and be assistive more than regulatory and try and bring everyone to the fold that way.

DR. MURPHY: I think they need to

realize that is part of their responsibility if they are going to do these more intervening processes, or, you know, treatment methodologies. They have to be on the other side of it giving us the information, interacting with us and have an active medical director so there is a full QA process or educational process. So it's a huge mountain, it's is a huge thing if you talk about all the BLS providers in the area.

MR. PARRISH: At the regional level they have to apply to us anyway to go to --

DR. MURPHY: We are talking about -- it's not really an application, what they are doing is submitting the paperwork and we are acknowledging, but we don't vote on it, we don't approve it. As soon as they have it and if they have their ducks in a row, they have a medical director, the education process, the QI process, they show us how they do it, it's a rubber stamp from there. I would be reading them today, but we don't vote on it. We are not approving them, it's approved by the State. We are announcing it,

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we are acknowledging it, but we don't --

(Everyone is speaking at once.)

DR. MURPHY: So, Nelson, you could speak about this.

MR. MACHADO: Just to clarify, the PAD applications, the epi autoinjector applications and I believe the Narcan -- I have to look at te Narcan -- those two are State processes. And by statute it's not an approval process at the REMAC level, it actually goes to the Regional Council and then up to the Department of Health. Albuterol, BLS glucometry, those are actually REMAC authorizations, so are the AED for ambulance services. Those are REMAC authorizations and those do require a vote.

DR. MURPHY: I've always just notified --

MR. LaMARCA: Those are actual votes --

DR. MURPHY: The PAD they definitely do more of a process, they have the medical director, the whole thing.

MR. LaMARCA: The collaborative agreement --

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DR. MURPHY: Those are a little different --

MR. LaMARCA: Those are just notifications to us. The others are technically upgrades so they have to be voted on by the REMAC.

The way that we authorize them, at least in the past when I worked here, was that the REMAC had a blanket vote that said once they come in they are approved pending the next REMAC meeting and vote. So that's how we have been able to kind of process them and get them along. The fear is if you get an AED app from someone and somebody --

(The speaker cannot be heard.)

DR. MURPHY: When we moved the meetings to only four times a year that was the other issue, that was a lot of lapse time in-between. It's going to change -- I forgot about the nasal Narcan, that is another thing the State is processing, that they would be able to atomize Narcan and CPAP. I forgot about that too. It's still in discussion, there is no, you know, movement on it, but

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it's -- you know, these are things they are talking about doing.

MR. LaMARCA: I guess the question really is how do we strengthen the tie between the region or a REMAC and the individual medical directors of the BLS corp.? Because some of them have -- on their application of signed stuff have absolutely --

DR. MURPHY: That's what we are hoping to do this whole educational process because I think people really don't understand when they are signing as medical director what does that mean. I think the only way to do it is we started -- like we are talking about it's educational process, it's a thing where we need to incorporate everybody and not be fearful of oversight, but they have to do it. It's a thing where -- and you have to have an active medical director, somebody that knows what is going on. And I think some of these medical directors who are not ER doctors -- and I'm not picking on anybody -- or not really in the fold of providing prehospital

or emergency care do not realize the ramifications of that signature on the line. So --

DR. STUTT: There is an avenue for us, if we look at -- Bill had presented the information earlier about the intranasal Narcan and that was approved in early December. And it's not just a blanket approval, there is a whole process that the BLS agencies have to have. They have to have written policies and procedures for the intranasal program, for EMT training credentialing, continuing ed, documentation of credentialed suers, appropriate patient documentation, defined QA program, including appropriateness review by the medical director, policy and procedures for inventory storage, security and disposal. All of that is fine and meaningful, but only if somebody is reviewing that. And the final statement that they have -- well, item two on their agenda for what each agency has to do is perform quality assurance evaluations on each administrator the initial six months of the

program or longer at the request of the medical director. The third aspect is provide data to the REMAC upon request, that's where we can gain control in making sure it's being done with the medical director QA QI --

DR. MURPHY: The only problem is from a historical perspective that's the exact same thing that's in PAD, that's in glucometry. You know, you have to do these policies and procedures and have that whole thing up and running. We don't get the information and so, you know, we are supposed to, but people do not facilitate the information along. However, what we are going to try and foster is a more open -- and let's see if we can get more people to do it. I would think some people will be anxious and interested in trying to further their care and do more with their agencies. So we are hoping that is what is going to foster that collaborative approach.

DR. STUTT: So although it doesn't say what remedial actions we may take and what

punitive we may take it certain implies if we have the ability to request these things for PAD, Epipen, Narcan there should be some avenue for us to address what BLS is doing.

MR. VIOLANTE: So to sort of help with the process, usually BLS providers don't have to deal with the REMAC in any way, shape, or form, they just go to the State for answers and ALS have these side avenues through the REMAC before they get to the State. And what we are seeing is that more and more BLS providers are now having to take this avenue through the REMAC and there is this sort of contention or unsureness, do I go directly to State through the REMAC? What should I do? And we are trying to align so the REMAC has a greater ability over EMS, not just ALS --

DR. MURPHY: Correct. I think it has to be it makes sense, but it's new for these guys and for all agencies out there. So I think it's a process of oversight and people always shun oversight, but I think it's the only thing we can do. We have to do it --

MR. VIOLANTE: And there is no clear

answer from the State --

DR. MURPHY: Yeah. We don't -- the one thing that was an e-mail we received was, you know, he kind of almost had his hair stand up on his back to think about all the BLS agencies thinking when we came across and said, now you have to do -- so it's a thing where we have to take it one step at a time and -- but it's something that is crucial and education I think is the biggest way to go about an it. I think everybody wants to be educated. We will launch the program about BLS and get it going, but it's a thing where the integration is critical.

MR. LaMARCA: I think if we can find out who the medical director of every service is maybe that would be the place to go to meeting sort of electronic meeting to go over the roles of medical director, the responsibilities, you know, what problems are that should have some reporting back, they may start to tighten it up and they won't --

(The speaker cannot be heard.)

MR. LaMARCA: -- but I think for

education that might get the top dog more or less into the computer to really have maybe for the first time a discussion about what they are supposed to be doing as medical directors.

DR. MURPHY: And the other thing I was thinking is trying to do some kind of regional meeting, like do we go over to Sullivan, you know, and try to do Dutchess and Ulster? And I would try and do that so would could have these educational forums. But you are right, the medical director is going to be a tough nut to crack.

DR. STUTT: If they want to do the adjuncts they have to do it.

Bill, put together a QA/QI project along with the Narcan documentation of who is trained, what the medical director -- so we have that information and it has to be returned to the regional office. After each administration they have to document under what situations they gave the Narcan, how the patient responded, signed off by the medical director and send to the Regional EMS office,

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so there is an avenue --

MR. LaMARCA: But that's only if they choose to pursue the intranasal Narcan.

DR. MURPHY: Correct.

MR. LaMARCA: We need just all of the medical directors period. Because half of them may have their name stamped to something that they have no idea already is going on, or they had some responsibility to oversight. I'm saying this is good to get some --

DR. STUTT: We should have the same format for all adjuncts that are used and have the capability of reviewing and making decisions about appropriateness of use.

DR. MURPHY: When you look at PADs it's supposed to be the medical director is supposed to notify every time they use the equipment. I can tell you, I have some agencies -- I can think of some police people I helped get PAD sites up and going, I assume they have used it once, I never heard from them. Maybe I'm wrong.

Do you have any BLS agencies under your belts, or Erik, where are the BLS in

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Westchester or up here?

DR. LARSEN: In Westchester I used to have one.

DR. STUTT: I have New Paltz Rescue and they are scrupulous about the PADs.

DR. MURPHY: I have one I get those PCRs every single month in the mail, it's incredible.

DR. LARSEN: I have one police agency every time they use it and they use --

(Everyone is speaking at once.)

DR. LARSEN: -- they send me a complete report.

DR. MURPHY: That's what is supposed to be so you can review and make sure the indication of the usage and the outcome was effective. Are we making headway with all these advantageous things we are putting out there? Are we saving lives?

MR. VIOLANTE: I just had a call yesterday, the family gave Narcan to the overdose patient before the medic got there. He was like what do you want me to do? It was done.

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DR. MURPHY: A lot of guys can go back down again if they are chronic users. You have to take them in because in an hour -- do you guys know families are being given Narcan to use Narcan to use on family members they know are narcotically in use? They actually give them Narcan to have. It's pretty wild, but it's true.

DR. LARSEN: In the south Bronx they were using it -- some of the big dealers were using it just as a testing. They would try out some new stuff and the person overdoses, they give them some Narcan. They are getting black market.

(Everyone is speaking at once.)

MR. LaMARCA: It was part of their safety program --

DR. MURPHY: It was their QI project --

(Everyone is speaking at once.)

DR. MURPHY: All right. So I think, you know, is that good?

MR. VIOLANTE: That's good.

DR. MURPHY: So I'll keep you guys updated. We are kind of -- we have taken the

collaborative protocols committee, the committee meeting and doing all this and said we are getting a move towards the BLS thing. So I'll keep everybody updated. The first and foremost agenda item is getting education out and starting the whole process --

DR. STUTT: Bill, raised the question should we vote to approve the use and offering of IN Narcan for our region? Whether we need to or not, I think we need to say this is our standard in our Region. The State has given permission to use IN Narcan, to solidify our permission we should memorialize this with a vote, this is how we are going to do it, the control, the education, QA, QI, and reporting.

DR. MURPHY: I think -- do people have enough information to make a vote today? Do you feel comfortable with that? It's a New York State BLS protocols that they put out and so what they did was provide us with the application form, what the necessary items are people need to apply for, what they have to produce, that list kind of what Eric read

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off. So if everyone feels comfortable I'll put it on the agenda for a vote.

Does everyone feel --

DR. BENNEK: I think so.

DR. MURPHY: Put a motion on the floor.

DR. STUTT: I move we approve REMAC and EMT agencies that wish to use Narcan that they will comply with our education, Q and A, and reporting requirements.

DR. MURPHY: Let's put it forward to a vote.

Any comments, issues?

All those in favor? I think everybody --

MR. HUGHES: Unanimous.

DR. MURPHY: Thanks. Our QI project and QA projects here in the office are on hold. As us know from the last meeting we discussed Emily was leaving. We started interviewing people for the position. Bill?

MR. HUGHES: Several interviews -- actually we had 12 people that applied. I interviewed all of them on the telephone and the executive committee interviewed three

people on Friday, the final three we thought would be good. And we have a candidate and we will be making an offer probably this week.

DR. STUTT: Good.

DR. MURPHY: She is at Phelps Memorial, but I thought -- I'm going off the chart. She is applying also to doctoral positions and going back to school.

Service upgrades, I don't have any.

Evaluation subcommittee report, we didn't have any concerns.

Helicopter committee report? Did you want to talk about --

MR. ANDERSON: Dr. Stuhlmiller apologizes for not being in attendance, he had a conflicting meeting.

I think all we had to put out is we are scheduling a meeting for February for the committee to review and update the helicopter operation guidelines with the intent of drastically decreasing its size.

DR. MURPHY: We had also received this -- you know, the Air Methods handout

from the last meeting with, you know, the criteria, the table of contents and such. I don't know if you saw this?

MR. ANDERSON: I guess I should have if you got it from us.

DR. MURPHY: Yeah. You might not have known it came across. We will make sure it gets into the minutes and everybody can take a look at it.

DR. LARSEN: We also have as part of the air medical service we also have folks from Hackensack here that provide --

MR. ANDERSON: You guys stop sneaking in.

DR. LARSEN: -- who provide good service coming up from New Jersey from the south so they cover the kind of south rim of the Hudson Valley here so they have been playing a much more active role and it's good to see them.

DR. MURPHY: Welcome.

MS. HAYES: I just wanted to introduce myself, I apologize for being late. Lynn Hayes, I'm the regional clinical manager for

Life Net of New York so I work with Steve. And my background is I'm a nurse and paramedic and flight nurse for 10 years on Life Star. And this brings back memories because I was the State EMS coordinator in Connecticut for like the early 2000s.

DR. MURPHY: Well, welcome. Thank you. Anything you want to add in the back? Would you like anything to add to the meeting or --

SPEAKER: We are good, thank you.

DR. MURPHY: Okay. So quality improvement report, I'll say on hold for right now.

MR. HUGHES: Yes.

DR. MURPHY: New business. We have a couple things, one is our collaboration with BLS, which we kind of brought up and talked about. But one thing not on the agenda that I wanted to add is, we received information and a request from the State EMS, specifically Lee Burns, to look -- and we need to discuss and maybe form a TAG to look at trauma care in our region. As you know, trauma care is changing. St. Francis is in

the process of merging with Vassar and become part of the Health Quest system. And Vassar, Orange Regional and St. Luke's have all applied to the State and are looking at trauma qualifications and consideration for a certain level designation. And so what Lee had said, she wants assistance from both the REMSCO, REMAC and entire EMS community, looking at updating our trauma transportation protocols to address the closure of St. Francis when and where that time comes, looking at the trauma protocol that we have and kind of getting the word out in the educational process that these new designations are in the application process. Orange Regional has put through all their information and their application as a level three trauma center, St. Luke's is seeking verification for level three trauma center and Vassar is actually look at the level to be determined, two or three.

So these are all processes that we need to make sure we have in play and that we kind of keep an eye on and give input for and try

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to designate what we think is the right format for our region.

MR. LaMARCA: When you are saying the levels you are talking about the new levels or the old? Like what did you say Orange Regional --

DR. MURPHY: They want a three.

MR. LaMARCA: Which would be the equivalent of what a two is now --

DR. MURPHY: A two is now.

MR. LaMARCA: I think that's why we are talking apples and oranges. We don't have a great perspective on EMS from what the differences are.

DR. MURPHY: Yeah, I have to say, neither do I to be honest with you. Because it changes and then the whole thing of -- like Orange Regional, for example, the doctor there approached me about it because the trauma doc, you know, has put through all the paperwork, has put all this stuff in motion and has almost like 80 percent of the way filed to have the 24 hour coverage. So they're like, can we start with just a

smattering of patients? Like start to get some patients going so people get in the mode -- not that they want to be inundated because they don't have the designation yet, but people that walk in or things that happen to occur there versus having the designation and having EMS deliver the patients there. So it is a gray area. I don't have an answer for that. I don't know, what do you do? Do you say to the agencies, okay, this is what is on the horizon, this is what people are applying for? They have everything in order, but have they been given the sign of the cross yet? No. But it's a thing where it is down the road and with the whole St. Francis thing that throws another wrench in the soup just like when the psyche changed and people went out of business and we had to reorganize care and such.

So I think the easiest way to do this is to form a TAG for trauma. What do you think about that? I think --

MR. VIOLANTE: I think Andy and I are out.

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MR. LaMARCA: We are tagged to death. I think you do need to have at least a way of us equating old system potentially new system and a time frame. From what I understand we are not looking at the new one taking place until 2015.

DR. MURPHY: Correct.

MR. LaMARCA: This is where we are now, we will see what happens across the river at St. Francis. I don't think our system will change much until then so you are going to ask us to make an educated decision about what it might look like versus what it is today.

DR. MURPHY: And the other thing I think is important that we have them reach out, that the hospitals reach out to the EMS agencies in their area. One of the things Orange Regional is talking about is this spring we do a drill and, you know, we do -- look at you --

MR. LaMARCA: It was my suggestion -- we talked to Dr. Shiley (phonetic) at Orange Regional, the trauma surgeon, about this and

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we are kind of concerned about in the evolution or development of these programs if we are going to give EMS any message we have to be very clear. We don't want them thinking that a new trauma center opens up and them taking somebody to a level one and they should have called helicopter and flown them out. We have to be very careful when we reach out to EMS and I don't think many of the hospitals have a good understanding. It's like flipping a switch, either you are or aren't and once you say you are, we are going to -- I mean we are always on the tail end chasing trying to education them on what they should take in, defer and take elsewhere. We understand if there is a crisis bring them to the closest hospital, you are asking them to make decisions about level of care. When BLS hears it's a trauma center they will take them or send to them to the helicopter. We have a problem with paramedics meeting BLS telling them we don't need to fly this person or we can go to this hospital so --

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DR. MURPHY: I didn't have an answer for her. I said when I go to SEMAC I'll talk to the powers that be. One of the things I thought about that Lee brought up in the e-mail -- I've never gone to STAC (phonetic) so these are all questions.

MR. LaMARCA: If it exists --

DR. MURPHY: It supposedly does, stop it --

MR. VIOLANTE: It's an --

MR. ANDERSON: -- underground committee.

DR. MURPHY: It's a black market organization.

MR. ANDERSON: Internally with the program we are very interested as well because dealing with some of our out of state receiving centers Berkshire Medical Center Massachusetts is an ACS level state. A number of years ago Berkshire Medical Center had to drop to a level three ACS status with that because of the loss of neurosurgery. There were many other things part of that, our medical director felt that placed that hospital at a level of care which was below

what we should be delivering a patient to so they were removed from our list of receivable trauma center. Now with the State of New York and local facilities looking at that potential level three status internally we have to look really close to see exactly what is being done at these facilities. My gut tells me we are sticking with level one and level two as our destination for the trauma patient, but we are looking at it closely as well.

DR. MURPHY: The problem is all this stuff is happening and sometimes these decisions are made way before providers and prehospital people are aware.

One, I wanted to bring it up. And two, I'll talk to Lee on the 14th about, you know, the whole process. And, again, you know, she does say that she has a trauma coordinator so one of the things is ask the trauma coordinator to come to one of our meetings because it's touching a large region, even if she is over the phone we could ask questions and maybe get some clarification to their

thought process, the designation, where they are going from here, what they plan on doing across the river and such.

MR. LaMARCA: Oh, God help them --

(Everyone is speaking at once.)

DR. MURPHY: You always get me in trouble -- that's Andy LaMarca, Mobile Life.

I think what this does bring up though is us really getting on board and looking at a TAG to, you know, formulate and really look at our region and our -- because trauma is a huge thing and I want our providers out there to have some kind of guidance and idea of what is available and what is set forth.

So what I'll ask, if you are interested in forming part of a TAG if you could submit names, come see me at the end of the meeting, that would be great.

(Everyone is speaking at once.)

MR. VIOLANTE: You did not see Erik Larsen's hand up.

DR. MURPHY: Were you scratching your nose?

DR. LARSEN: Actually, has STAC put out

a timeline on this?

DR. MURPHY: No. It says -- I can quote -- I cannot stress enough the importance of this prehospital EMS at the table during this verification process and part of the changing landscape of our region and it's -- you know, they are moving so --

MR. LaMARCA: And I seriously think Lee wants to push as much work through as possible not knowing what will happen with the Article 30 changes, STAC, SEMSCO and the rest may actually disappear. So I think if she is at least left with those documents whatever the work product is, if things change it will help.

DR. MURPHY: Do you want to elaborate on that so everybody understands what you are saying?

MR. LaMARCA: The Article 30 changes proposed the last two years in the governor's budget obviously have been stalled in the past two years, sometimes because of substance and one of the big things was losing the statutory authority of like a

REMSCO. And even at the State Council other things were just the fact that they wanted to take from the eighteen regions down to six, that was last year, and this year it's rumored to be ten regions, so there is a whole bunch of things. There are positive things about language changes, but it was largely I think defeated politically because it was in budget and many of the elected officials felt that wasn't the way to do it. What I understand from Lee is they have had more concession, more discussion, it wouldn't be part of the budget process, but it will be something decided in the next legislative session. At risk is the fact that they have felt that there is far too many committees and advisory groups and STAC is one, SEMSCO is another. They are looking to really -- so if they can take all of them and kind of put them into one committee of like 30 or 32, I guess is what the recommendation is right now, State Council is representative of 30 or 32two representatives from across the State. So taking a lot of that stuff and bringing it

down to an -- I guess still considered to be an advisory body.

So we are not sure what is going to happen, but it's kind of thought in the short-term that will paralyze, you know, so much of what we are currently doing, both EMS side and STAC side. So I have a feeling Lee -- and Lee said she thinks will be approved, but doesn't think it will take place until 2015, which sounds like a far cry, but really not.

So we have a meeting -- next week is the State Council meeting, we have no idea if there will be another one after that. Whatever work product, TAGs, committees that were working, I think they are trying to light a fire. They are doing that because half of the committees never reported and I think they really wanted to see some work product in case we go into this change it's something to work with.

DR. MURPHY: Yeah. I think that was Dr. Shah, that the Commissioner of Health really wanted to -- some outcomes he was like, you

have all these things started, like the hypothermia project, all the projects what's the outcome? What is the bottom line? So I think that is where it all stemmed from. So there was a lot of changes, a lot of changes at the State level.

We will have to see what happens, you know, but Andy is right I get these invitations to the meetings and this is when it's going to be and you don't know if there will be another one, but we will go forward.

Any other comments?

SEMAC report, as I just said before, the meeting is the 14th so I'll give the report after that meeting.

PAD proposals, Epipen, Albuterol and glucometers, I have no proposals at this time.

I do have a few New York State Department of Health certifications.

We have Philip Lamonda had his New York State certification revoked effective November 19th. He is out of Roe New York for a violation of Part 800.

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We have Jasper Volunteer Ambulance out of Jasper, New York, suspended from operations for 30 days effective December 9th. Assessed a civil penalty of $2,000.00 for violations of Public Health Laws 3112, Parts A, B, and D.

And so they want to make sure we read those into the minutes. So noted.

Open forum. Anybody have any information or issues they want to discuss? Anything they want to bring forward to the table?

You have nothing, Dave?

MR. VIOLANTE: We are done.

MR. LaMARCA: We are burnt.

MR. HUGHES: I have this electronically, I can send it to everybody.

DR. MURPHY: That would be great. That Monroe Livingston thing we sent around, the advisory and articles about hypothermia, we will send it electronically so when we come back the next meeting -- what is the date of the next meeting?

DR. STUTT: First Monday in March.

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DR. MURPHY: Karen?

MR. HUGHES: Give me a minute, I just have to look it up.

DR. MURPHY: If everybody could come back on that we will decide regionally what we would look to do, if anything. And I'll come back with the stuff from Dr. Freeze, we should have the information from New York City --

MR. HUGHES: March 3rd, 9:30.

MR. LaMARCA: So if we get folded into the Westchester and Hudson Valley region are you guys going to cochair?

DR. MURPHY: No. Eric is doing it. How many years have I been sitting here? I would think you would want to listen to somebody else.

Anything else?

Do I have a motion to adjourn the meeting?

DR. STUTT: I move.

DR. MURPHY: Okay, second?

DR. BENNEK: Second.

DR. MURPHY: Thank you everybody.

THE FOREGOING IS CERTIFIED to be a true and correct transcription of the original Stenographic minutes to the best of my ability.

Yvette Arnold