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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, March 3, 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. FRANCINE BROOKS,
Evaluation Subcommittee Chair
DR. DAVID STUHLMILLER,
Helicopter Subcommittee Chair

WILLIAM HUGHES, EMT
Executive Director HVREMSCO
JEFFREY CRUTCHER, QI Coordinator

BON SECOURS COMMUNITY HOSPITAL

DR. CRAIG VANROEKENS,
Physician Representative
HUDSON VALLEY HOSPITAL
DR. RON NUTOVITS,
Director

NYACK HOSPITAL

DR. MARK PAPISH, (Via Telephone)
Director
DR. SHAH, Physician Representative
(Via Telephone)

ORANGE REGIONAL MEDICAL CENTER

DR. DAVID CORNELL,
Physician Representative
ST. FRANCIS HOSPITAL
DR. GARY NEIFELD,
Physician Representative

SHARON HOSPITAL

DR. RICHARD BENNEK,
Director

A P P E A R A N C E S : (Continued)

WESTCHESTER MEDICAL CENTER
DR. JON BERKOWITZ,
Physician Representative

WESTCHESTER REMAC LIAISON
DR. ERIK LARSEN,
Physician Representative

GOOD SAMARITAN HOSPITAL
DR. DENNIS MAO,
Director

ALSO PRESENT
DAVE VIOLANTE
ANDY LaMARCA
DR. WALDEN
JOE SOLDA
MIKE BENENATI
NELSON MACHADO
ANDREA DOWNES
MICHAEL BIGGS
ISRAEL KNOBLOCH
GINA BASSINETTE
MIKE MURPHY
BRIAN BATES
DAN SYLVESTER
TINA PANTES
FRANK CASSANITE
KEVIN GAGE
RICH ROBINSON

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DR. MURPHY: I would like to bring the meeting to order this morning. Everybody, thank you for coming.

I will ask again we go around the room just to have everyone say who is here.

And so Dr. Pamela Murphy, the REMAC chair -- I think you guys are sick of listening to me.

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

DR. MURPHY: I want to welcome the new QI Coordinator --

MR. CRUTCHER: Jeff Crutcher, good morning.

DR. MURPHY: Jeff, can you talk a little about what you expect? What you want to do going forward?

MR. CRUTCHER: Well, basically I have been learning kind of the ins and outs, spent a little bit of time updating the website. At this point in time I'm going to go forward and make sure all the agencies have active QA/QI programs running, going through some of

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the folders lacking in --

(The speaker cannot be heard.)

MR. CRUTCHER: -- going forth with internasal Narcan, a lot of interest with agencies with that and bringing agencies on board with the EPR.

DR. MURPHY: Great.

DR. VANROEKENS: Greg VanRoekens, Bon Secours.

MR. LAMARCA: Andy LaMarca, Mobile Life.

MR. VIOLANTE: Dave Violante, Arlington Fire District.

MR. BENENATI: Michael Benenati, protocol committee.

DR. NUTOVITS: Ron Nutovits, Hudson Valley Hospital.

DR. NEIFELD: Gary Neifeld, St. Francis.

DR. BERKOWITZ: Jon Berkowitz, Westchester Medical.

DR. BENNEK: Rich Bennek, Sharon Hospital.

DR. LARSEN: Erik Larsen from White Plains Hospital and representative of the Westchester REMAC.

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DR. CORNELL: David Cornell, Orange Regional Medical Center.

DR. MURPHY: Thank you.

DR. BROOKS: Fran Brooks, Vassar Brothers Medical Center and evaluation subcommittee chair.

DR. MURPHY: All the guys in the back? I want to hear from everybody in the back.

MS. DOWNES: Andrea Downes, NDP EMS, Sharon Hospital EMS.

MR. SOLDA: Joe Solda, Air Med One.

DR. WALDEN: Dr. Walden, the medical director, Hackensack University Medical Center EMS.

MR. MACHADO: Nelson Machado, Rockland Paramedic Services.

MR. BIGGS: Michael Biggs, New Windsor Ambulance.

MR. BATES: Brian Bates, Blooming Grove Ambulance.

MR. SYLVESTER: Dan Sylvester, Blooming Grove Ambulance.

MS. PANTES: Tina Pantes --

(The speaker cannot be heard.)

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MS. PANTES: -- manager at Good Sam.

MR. CASSANITE: Frank Cassanite, Orange County EMS coordinator.

MR. GAGE: Kevin Gage, New York State Department of Health.

MR. ROBINSON: Rich Robinson, New York State Department of Health.

MR. MURPHY: Mike Murphy -- no relationship -- Rockland Paramedic Services and protocol committee.

DR. VANROEKENS: He is quick to point that out --

DR. MURPHY: I don't think he breathed in-between the announcement and saying he has no relationship with me.

MR. KNOBLOCH: Israel Knobloch, Kiryas Joel.

MS. BASSINETTE: Gina Bassinette, New Paltz Rescue.

DR. MURPHY: Come in and sit down.

First on the agenda, I would like a review of the minutes from our January 6th meeting. I'll accept any additions, deletions, corrections and --

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MR. HUGHES: Dr. Shah?

DR. LARSEN: Dr. Shah? Are you present?

DR. SHAH: I am, yes.

DR. MURPHY: You are right, we were supposed to answer that phone.

DR. LARSEN: Dr. Shah, are you there now?

DR. SHAH: I'm going to -- I also have Dr. Papish conferenced on my phone as well.

DR. MURPHY: Great. So you have Dr. Papish and Dr. Shah. And Dr. Stuhlmiller just came in. Good morning.

Can I have a motion for the minutes?

DR. BROOKS: You want me to ask --

DR. MURPHY: No, make a motion.

DR. BROOKS: Motion to accept the minutes of the last meeting.

DR. BENNEK: I'll second it.

DR. MURPHY: We are going to have to turn him down a little bit.

Any additions, corrections, deletions, anything different? Thank you, everyone.

I want to go through a few little old business issues. One is in terms of medical

control credentials and the whole rollout process and everything. We still have some people that -- some hospitals that still need to have some physicians complete paperwork, getting in their exams and such, but as a general rule most of them are doing well. We have some from Catskill, some from Putnam and some from St. Luke's that still need to be completed.

In terms of a collaborative type of protocol rollout with BLS, as you know, the new protocols have a few instances where BLS is in our new protocols. And with the things that are happening in the State, like Jeff was talking about, the Narcan and such, the BLS assisting the patient with taking their nitro in the chest pain protocol, we have to integrate these two things. So what I've done so far with the help of the protocol committee is go to Sullivan County -- sorry -- Orange County so far and met with the BLS agencies so that we all are on kind of the same page and I introduce the protocols where the overlap occurs. Tomorrow

night I'm going to Sullivan County. Frannie is going to do Dutchess County. And I have to work out the remaining counties. But it's really so that we can get the information out there and people to realize that the BLS does have some overlap and integration with our protocols. So that we -- you know -- do this altogether moving forward.

Any questions?

So so far the whole protocol rollout has been, you know, an eye opening experience. It hasn't been perfect. Sorry we were so long in getting out the new exams for new people, but it's a thing where this was a monumental task. The protocols really haven't been revised in so long and already we already had a meeting for the collaborative committee to start changing the protocols again. Like I told you before, it's always an ongoing thing. In 2015 we will probably come out with another round to bring to this committee so that we can go over and go through the protocol committee. So it's a process that's never-ending, it's a

process that is always going forward. But thank you for everyone's support and especially the protocol committee and a lot of people in this room today.

Any other comments? You are good with that?

MR. HUGHES: Nope.

DR. MURPHY: Next is service upgrades. We have no service upgrades to bring forward today. However, it does bring me to talk about -- make sure everyone is on the same page about service upgrades.

Service upgrades include when an agency wants to take on an advanced level of care that it has to go through the official process of ALS upgrade. Meaning, the application process, it goes through a CON process, it goes through a public hearing process, it goes through a 90 day commentary process. There is a whole process so that we make sure we are not diluting care, we make sure we are providing care in the right areas and that we have appropriate resources out there.

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So we did receive a letter about an agency putting and -- leasing an ALS provider so I'm going to meet with them and talk to them because that is really not the way an ALS upgrade is done. So I'll get back to you on that. It's something that is new and just been put forward.

But there is no new service upgrades today.

Frannie, evaluation committee?

DR. BROOKS: Yeah. There is one case that has been outstanding that we met with this morning to have some resolution -- just in a nutshell.

A patient who had had a recent cardiac stent for chest pain several days prior sent back to where they live, had chest pain again. Paramedics came to pick the patient up, evaluate the patient, treat the patient and transport the patient. It was going to the closest most appropriate hospital, that hospital diverted the patient to a hospital actually outside the region. And it was -- ended up not being a cardiac hospital at all.

The patient's chest pain was resolved after treatment by paramedics. The patient arrives to the emergency room that they were diverted to and had a cardiac arrest and succumbed.

This case was brought to us by the Department of Health to evaluate. We know the hospital in question that diverted, has had numerous conversations and meetings and came to conclusions, the paramedic agency, the same, with their paramedic and other members of the agency. We had decided two-fold, number one, we felt that this should be a learning opportunity. The patient should have been brought to the closest most appropriate facility. The paramedic should be able to override or -- I won't say turn against -- but override the physician's decision if the closest most appropriate hospital is the most appropriate hospital and the paramedic is uncomfortable taking the patient elsewhere on a longer journey. And we would support that. And that we would send a letter to the two individuals, the physician and the

paramedics, and more education saying that this is what we had agreed upon and decide which would have been in the best interests of the patient. And we would send a general letter out saying that patients as per protocol should be taken to the closest most appropriate hospital.

The reason we don't want to get more involved, there maybe litigation in this case. We are protected under QA, we don't know -- other letters saying more specific things we will get to. And the Department of Health has done investigation, we don't know what their findings are and we felt more comfortable leaving it just with those two letters, again, to the individuals involved and then a general letter that patients must be brought to the closest most appropriate hospital and shouldn't be diverted where they shouldn't be.

Any questions?

DR. MURPHY: Okay, thank you.

Dr. Stuhlmiller, helicopter committee?

DR. STUHLMILLER: A request was made at

the last REMAC to review the operations guidelines for the use of helicopter in the region. I received some comments from the committee. We do not yet have a revised document to present to the REMAC. We will try to have that ready for the next meeting.

DR. MURPHY: So it's just you guys have a work in progress -- it's okay. When is the next meeting?

DR. STUHLMILLER: I haven't scheduled it. It will be before the next REMAC meeting.

DR. MURPHY: Just put it out to Karen and she can get it out to everybody so if people want to be involved and be there, or, you know, be involved in the process.

DR. STUHLMILLER: Absolutely.

DR. MURPHY: For sure. Any other comments?

QI? I can't imagine Jeff you have much you want to say --

MR. CRUTCHER: Not as of yet.

DR. MURPHY: -- as of this point, but, you know, going forward I think everybody

heard your introduction so only a few people came in after.

Under new business, one of the things I forgot before was we need to vote on and talk about hypothermia, as I mentioned at the last REMAC meeting. We had SEMAC in-between and, you know, were given some more information from the program in New York City under the hypothermia protocol. And like I had said to you before, it's a little bit different than what we have up in this region. In New York City they had a designated ambulance that could respond to these calls when they had return of spontaneous circulation so it's very different than what we can do up here. And long story short, that is the reason I put out those articles.

Anybody able to read them and review them?

The basic issue there is, you know, really it's not panned out to be as beneficial as we had thought from the beginning. So what I would like to do is put a motion on the table right now for everyone

to at this point stop and remove hypothermia protocol from our local protocols. The collaborative committee has already made that motion so the next round of protocols is they are going to put forth to get rid of the hypothermia, but I wanted to bring it back to this committee and have comments and people tell me how they felt about it and et cetera.

Erik, you are smiling.

DR. LARSEN: I don't ever like to say what I really feel, no. No, I think that's appropriate. I think, you know, a number of us have talked and this is kind of pretty much the date that that is out there. I think this is what we should go with. I don't think there is any really counted strong argument to, you know, start the hypothermia and I think it would basically have a detrimental affect.

DR. MURPHY: That's what those articles talked about. I would like a motion on the table to remove the hypothermia protocol from our protocols. And we will put it out as an advisory for now, but it will be revised once

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the new protocols come through.

All those in favor?

DR. BROOKS: I'll second the motion.

DR. MURPHY: Sorry, guys -- all those in favor?

So we have one, two, three, four, five, six -- so it's unanimous. Thank you, everyone.

DR. SHAH: Aye.

DR. MURPHY: Sorry, Dr. Shah. I forgot again, I'm so bad --

DR. SHAH: No problem.

DR. MURPHY: Thank you everyone for doing your homework.

Under new business, I had mentioned at the last meeting we had received a letter from doctor -- sorry -- from Lee Burns at the Department of Health to start talking and start looking at our region and how the resources and such we would be, you know, proactively looking at for trauma in our region. And on February 21st Regional Trauma Advisory Committee met at ORMC, I was working so I could not go.

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Do you want to give a quick synopsis?

MR. HUGHES: Sure. There was quite a few things discussed there.

One of the things, they did create a TAG to discuss tranexamic acid and hopefully they will have a report on that for the next RTAC meeting.

We discussed the Hudson Valley Region area adult and pediatric age limits because different hospitals have different definitions of what the pediatric age is. The Hudson Valley and the collaborative protocols and Westchester use the age A guidelines and where pediatric patients are, you know, at signs of puberty, not having signs of puberty, where Westchester Medical Center uses the age 14 and above, so 13 and below are pediatric so there was some discussion on what is going to happen there.

The STAC and the RTAC are trying to partner a lot more with EMS organizations to try and get some of the better improved performance within the trauma system. So, you know, there has been a lot of talk with

that. There was some data sheets supplied by Westchester Medical Center about trauma coming to them and to try and get an idea what facilities are transferring trauma into Westchester. And that's going to be the beginning of some of the stuff they study as to the -- what the results are and patient outcomes.

They have setup a website for the RTAC where there will be some information there pod cast, video cast, and we will be able to sign onto the website and review that.

We also have discussed traumatic brain injury. And it's going to become a project -- I guess it's the STAC that created or requested that each RTAC create projects within them to help improve the system. And one of the things -- one of the projects that the Hudson Valley Region RTAC is looking at is going to be traumatic brain injury.

And we discussed some stuff on EPCRs. And we have -- our next meeting is scheduled for May of 2014 at St. Luke's. I don't have the date yet as of yet.

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DR. MURPHY: It will be at St. Luke's though?

MR. HUGHES: Yes.

Some of the physicians were there, if they have something to add, that's great.

DR. MURPHY: Dr. Cornell?

DR. CORNELL: It was pleasure to host the RTAC at Orange Regional Medical. And dovetailing off what you stated, STAC kind of requested the RTAC and the State to submit two programs that were extra hospital extended; i.e., EMS. And review of Dr. Marini running the program felt that TBI over 50 percent, or roughly 50 percent of the transfers into Westchester -- Dr. Berkowitz can comment -- are roughly traumatic brain injuries. And, clearly, we transfer a few here and there ourselves from Orange Regional to Westchester.

And so my concern was that perhaps standardizing some type of transfer protocol to keep these folks -- these patients that have TBI from becoming hypertensive and any significant hypertensive in TBI increases

mortality by about 50 percent. That is what I was hoping to bring to the table here sometime today.

DR. BERKOWITZ: I agree with that. We talked a little after the RTAC, saying they're not really denying interfacility transport protocols and especially something we are doing so many of. It would be a good target to collaborate on to make sure the patients are transported safely. Because even small, you know, changes in their oxygenation or blood pressure can really have -- affect the long-term prognosis. So this is something we're discussing now and trying to figure out the best, you know, mode to attack it, whether it's the REMAC, the RTAC, or what other acronym that gets involved. But certainly I think -- I think Dr. Cornell pointed out an area that is a good area for us to look at for interfacility transport.

DR. MURPHY: I think in the past there has never been like interfacility transport protocols, per se. Because it was difficult

and the way it is setup we weren't really governing things that happened outside of our realm, meaning what hospitals do and hospitals wanted to maintain that ability to transfer patients and such and we never really dictated. However, it would be great to have things out there for people to go by, helpful for them to utilize. And, you know, that was always a discussion that comes up when we do these protocol revisions. And it did this last time too, but it's very -- we have never really set forth specific entities for interfacility transports.

Andy?

MR. LAMARCA: Just as a point of clarification, I think Dr. Haddock at State Council along with STAC is talking about putting together that same thing to look at transfer protocols for trauma cases. So you might want to contact --

DR. MURPHY: Yeah. He had actually -- I was going to say it when I got to the SEMAC -- he put me on the STAC committee so I will, you know, be involved on that level too

with you. It's a thing where this is a new area we are looking into is really to have that really continuation so that there is, you know, good oversight, good things for people to go by. And I don't look at it as a regulatory thing, I look at it as being a helpful thing for the medics so the medics have something to protect them. You know, one of the things I think happens in interfacility transports is, you know, they get to this hospital, they have to pick up this patient, and maybe the patient is not stable and maybe they're having to transport this patient that could deteriorate like readily. And they like to have the support and they could feel uncomfortable and, you know, I think having someone -- they always can contact medical control, but to have some kind of information to go by and, you know, improving education and all these things on trauma. I think we have a lot to do in this area so that we deliver a very good trauma care prehospital. And, you know, that is one of our goals this year coming forward is to

look at our resources, look at what we have in the area and make sure that we deliver it and, you know, provide support for the prehospital people. So thank you. And what we'll do is, hopefully between the two of you guys and Bill and hopefully I can get to the RTAC meetings too, is we will bring back information to this committee and kind of keep it altogether. But that was definitely an emphasis Dr. Haddock had at SEMAC is making sure these forums get up and going and integrate and bring the information around.

MR. LAMARCA: I'm not sure this is the place, but the number -- talking about the change in the mindset as far as backboards, but with research out there it looks like we might be getting some changes coming down from Albany. It might be something for that committee also to look at how we are going to recommend, you know, that we actually no longer use backboards and many of the cases --

(The speaker cannot be heard.)

MR. LAMARCA: -- so we would like to put

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that out there. Maybe that is something you could consider and have discussion on.

DR. MURPHY: Dr. Dailey brought to SEMAC -- you guys are totally getting me into the SEMAC report -- even he brought forward the latest thoughts from trauma committee and he brought up for everyone to read about selective use of backboards and so it is something that is out there. And one of the emphasis is when a patient comes in with trauma to get them off the backboard as soon as possible and that's really the new trends from STLS and really good trauma care. He brought it forward to SEMAC so that discussion can occur. Because it's always been in the past everybody got backboarded and collared no matter what and that came to light everything goes full circle, that's why we are doing BLS CPR on everybody. So it was a thing that was up for discussion and it's definitely an idea where we do need to allow certain people to make that clinical judgment, but we definitely with a mechanism that it requires it definitely use the

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backboard. But that's, again, another -- that's also being, I guess, addressed at the STAC committee. And so I'll get people and bring that information forward, but that's another thing on the agenda from SEMAC.

Any other comments or questions?

I just wanted to give Dr. Neifeld the floor for a moment to just discuss -- give us an update on St. Francis.

DR. NEIFELD: St. Francis, as everyone knows, had some financial difficulties and went into Chapter 11 bankruptcy. And St. Francis has emerged from that partnering with Westchester Medical Center, our services have not been interrupted and remain strong. Our core services at St. Francis are trauma, mental health, community medicine, early childhood education and there has been no interruption in care. We hope to come out like the airlines, stronger than we came in. We are partnering with Westchester and as time progresses there maybe some added services that are brought into St. Francis. We are not in competition with Vassar or any

other hospital, we are mission driven community hospital, we want to give the best care we can to the members of our community. And EMS should know that we are there, there has been no interruption of services, we are on a solid footing and as time progresses we hope to add more to the community.

In terms of our trauma program, which affects most of the EMS community we -- again, no interruption of services, five full-time trauma surgeons in-house 24/7 with PA backup, emergency physician. We are proud of the trauma care we provide, the only thing that is going to change is the name of the hospital.

DR. MURPHY: What is it changing to?

DR. NEIFELD: Good question. We are open to suggestions.

DR. MURPHY: There is a box at the door put your suggestions in -- you win -- no --

DR. NEIFELD: Just the sisters at St. Francis who established the hospital a hundred years ago have graciously given up their ownership of the hospital and because

some of the services that may change and some of the religious driven initiatives may not be the same they thought that the name should be changed.

So the actual closing date with Westchester is May 9th, but all the I's have been dotted and T's crossed. The message is that we continue to be a full-service community hospital and we, you know, welcome all EMS business and we want to do the best job we can as we always do.

DR. MURPHY: Thank you. Any comments or questions for Dr. Neifeld? Thank you.

Also, I should have brought up during the collaborative protocol discussion under old business, there has been a little confusion about the transition from RSI to MFI. And what we had said at the protocol committee and worked through with accepting the new protocols is was that transition to occur that people that are RSI credentialed as of that point are still -- will be allowed to be MFI, we just need to make the transition of nomenclature of the new

protocols and just like anything we are rolling out it has to be incorporated. There are changes with the new protocols such that the second medic is on board and involved, so not all of the nuances have been worked out. I'm trying to do the BLS integration first and then we will move forward and have all the required information and procedural process and forms -- of course, we always love forms for MFI. So far the information is out there for people to apply to become a new MFI agency, that material is out there, but I wanted to get through the BLS kind of integration first and then we will move on.

And we are going to have another meeting with the protocol committee to move these kind of outstanding issues forward and that will be forthcoming. I will put out an advisory for the successful transition period so people who are doing RSI in the past can do MFI now so that there is no lapse in the delivery of care. We have to still provide care even in the nuances of changes in advancement of care, we can't stop what we

are doing, so just to cover people so there is not a problem there. We will have and request everybody within the next six months or so, we will come up with dates, and, you know, some specific timelines to try and get everyone to put new paperwork in just so we have an accurate roster of who is -- you know, the three agencies, Blooming Grove, New Windsor, and Mobile Life, just so we know who is your current RSI guys that now will be MFI and go forward from there and such.

Any questions? Comments? Because Blooming Grove is here, New Windsor is here too, right? So any comments or concerns? Okay.

Under SEMAC, we had the SEMAC meeting -- when was it, January what? I can't remember now. But I already mentioned quite a bit that came down from SEMAC. Dr. Haddock, you know, is now the chair of that committee and moving things forward. I definitely think it's more organized and, you know, we're really trying to provide and organize so that we move care forward and keep projects at

hand. I can't think of anything else I have to bring to this committee.

MR. LAMARCA: The only other thing I will say is the net effect of the collaborative protocols left Dr. Marshall with over half of the medical standard meeting with nothing to do with SEMAC, almost hours of discussion like overnight disappeared.

DR. MURPHY: Yeah. You know, in the old days what happened was every single region brought protocols forward and now that we have made a collaborative effort from Westchester up to the Canadian border so many of us are now using the collaborative protocols, it works out great. We are all on the same page, we're all doing the same thing and we can, you know, institute, improve, make things better. It's really taken a lot of the nebulous and kind of nuances of discussion out of that committee. It used to be torture, medical standards. We'd be there for three hours, you know, nitpicking through everybody's stuff. It's nice everybody is

kind of joining on and using the same protocols, which is what the State wanted in the beginning is to try and get everybody on the same page. Could we have a statewide protocol? Well, we all kind of decided that we cannot with New York City and New York City is part of the State but there will always be something different because it's different. And we will --

MR. LAMARCA: But New York City didn't teach us anything at the last meeting, they usually lecture --

DR. MURPHY: Well, they did. We are taking away hypothermia.

MR. LAMARCA: It's Dr. Frost --

DR. MURPHY: Freeze, Dr. Freeze. It was very important and appropriate that he had that TAG and that project. Okay --

DR. LARSEN: So just a question there, so are there other areas of New York State that are doing similar to what we have done?

DR. MURPHY: Well, our collaborative process is really from Westchester to the mountain region, so it goes all the way to

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the Canadian border. So it involves the REMO -- help me guys AER EMS --

DR. LARSEN: Yeah, I know what it includes, but not all of New York State --

DR. MURPHY: No one else has done it --

MR. LAMARCA: There are a couple in the western that have had collaborative protocols, but not these --

DR. MURPHY: Yeah. I think -- off the record for a second.

(Discussion held off the record.)

DR. MURPHY: Back on the record.

Long Island, Nassau and Suffolk fight. They about their protocols. So I don't know in terms of Long Island, that it might not work either, it's funny --

MR. LAMARCA: They probably don't speak the same language. It's a language thing --

DR. MURPHY: No. And it's funny they really have differences in how -- and it's not much different really. But that is what is good about the new collaborative protocols.

MR. LAMARCA: -- the blood

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transfusions --

(The speaker cannot be heard.)

DR. MURPHY: Oh, yeah, sorry. So this has been 15 years --

DR. VANROEKENS: At least.

DR. MURPHY: -- there has been a discussion, a committee, a TAG committee formed long ago and then it's been back and forth, back and forth regarding blood transfusions for prehospital providers to transport a patient with blood going. And it never quite came out of committee and it never quite came out of, you know, really being formulated and -- did the TAG ever come up with --

MR. LAMARCA: There is movement against --

DR. MURPHY: I guess it started again but --

MR. LAMARCA: They do have language already drafted and the agreement, minimal amount of training for the providers there, it will only be for currently infusing -- you know --

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DR. MURPHY: Yeah, something that's already started --

MR. LAMARCA: It will not be the change, so they are comfortable --

DR. MURPHY: Right. It's blood hung on a patient that you are transporting the patient. You are not going to institute --

MR. LAMARCA: That is all that was asked for --

DR. MURPHY: Yeah. They are not going to institute the infusion, but one already in the process of going.

MR. BENENATI: Can you just clarify where things stand? Because we have bumped up against that several times and they are saying you can't take the patient until the blood --

DR. MURPHY: Yeah. It should be imminently out is what they promise --

MR. BENENATI: If I meet a patient tomorrow with that scenario what is EMS allowed to do? It's not in the best interest --

DR. VANROEKENS: -- allowed by

regulatory code.

MR. BENENATI: Yes.

DR. VANROEKENS: Well, that's not what I want to hear. Unfortunately it's the same for 15 years, they can't -- and it's tied up in committee.

MR. LAMARCA: Obviously, it's jumped to be beyond the scope of practice for the paramedic level. So when it comes up we usually get a physician's order and self-report ourselves because Department of Health sends them a notice saying we had to transport this patient, so they know we are not hiding, but they --

MR. BENENATI: So when push comes to shove it's the scenario where the patient is at risk, you can --

DR. VANROEKENS: Right. Again, to make that clear, this entire body for the last 7, 8 years has supported that. And each person here basically signed off and said we support the appropriate care of blood products for patient safety. We don't care what the regulation are --

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DR. MURPHY: Yeah, but it should be coming down with something from the Department of Health to say that it will be incorporate into the scope of practice so then there be no discussion anymore. But I swear to God it might be even more than 15 years they have been talking about working on it --

DR. BROOKS: It has --

DR. MURPHY: The only thing -- and Andy made me remember this -- is there also is an entire form and TAG looking at paramedic medicine, you know. The whole thing of the new process of putting paramedics out there for community medicine and providing an extension into the homes.

You want to talk about that?

MR. LAMARCA: Well, I think that, you know, the more acceptable term now is mobile integrated health care. That's the first step. The second step is --

DR. MURPHY: Okay, Obama.

MR. LAMARCA: We are going only to pay 85 -- sorry -- I digress. I think many

people are relying on the changes to Article 30, whenever they take place, of including more verbiage that identifies nonemergency into areas that right now say emergency for operation of paramedic services. With that said, there is some thought that that really doesn't have to take place because currently right now ambulance services are certified by Department of Health for emergency work, but certainly part of that's also been nonemergency work and it really depends how it's setup. I think John Roscoe down to North Shore LIJ has, by his own admission, kind of like a Petri dish. That's the hospital system dealing with the hospital patient dealing with the hospital ambulance. They are able to -- I call it a public service model where they identify people at risk and address their disease entities --

(The speaker cannot be heard.)

MR. LAMARCA: -- diabetes, behavioral things that lead to readmission to the hospital, that kind of stuff for anybody else -- some thought we might need a little

change in Article 30 it obviously wasn't enough research, if indeed we do intercept the patient prehospital before they are in crisis or even after admission and target them we can do a lot. There are services that monitor patients at home. I interviewed a service that can do a full monitoring suite meaning noninvasive blood monitoring, EKG at the home, blood glucose --

(The speaker cannot be heard.)

MR. LAMARCA: -- to have a device to measure the electronic resistance of the chest and tells us if that patient is more likely to be in crisis, that is all meant to increase the need for readmission. In terms of long-term it is thought it will increase the need for ER visits in certain of the patients and along the same lines lead to the spin off to alternate destinations. The ambulances don't have to go to ER's all the time and not just free standing, but perhaps urgent centers, or if anybody looked at the EMS of the future back in 2000 arranging for the patient to be seen in a clinic setting or

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by schedule, the reason they called the ambulance is not acute, they could be seen at a later time.

It's a big discussion and the one thing we do know is nobody is paying for it right now -- which drives medicine for the most part. At some point maybe Medicare will bundle in hospital settings, if you are dealing with the readmission you face penalties, perhaps that money reinvested to provide the care at home. Then there is hospitals that are very proactive, are handling it themselves. There are nurse practitioners out in the field, it's being done already in different sort of, you know, venues. And I think that we can't put two or three of those programs nationwide that all are the same, they all have their own different issues, whether public service or hospital base. It's up and coming, yes. Will it be paid for? Don't know.

DR. MURPHY: The VA is actually doing a spin off of that right now, they call it the Healthy Vet Program. They give guys the

monitor, I haven't seen it I know a patient who has one and it does monitor all those indices you just said. He has it in his home. And what they did is select certain patients out of the VA clinic so they have more input --

MR. LAMARCA: If I'm working with a doctor, you know, straight to the --

DR. MURPHY: Yeah, straight to the VA --

MR. LAMARCA: -- we can send it to four spots, on the PDA, on the smart phone. So it has a lot of interesting bells and whistles, I guess I would say.

But when I actually interviewed that service provider, I said if I'm trying to work with hospital and decrease the 30 day readmission once we put them on the monitoring, it's less than 60 days. I said, why? Either by that time you correct it or it's no longer a 30 day readmission. It's revenue. I was just looking at the health side, it's remarketable, after 60 days you can readmit them, they are free.

DR. MURPHY: That's terrible.

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MR. LAMARCA: Anyone wants more information I'll tell you off the record.

DR. MURPHY: Tell me the new name?

MR. LAMARCA: Mobile Integrated Health Care. And there is a committee and a physician that is obviously in charge of the committee at State Council.

DR. MURPHY: Thank you. Any other comments?

Moving on. Two things also under new business. This Saturday, March 8th ORMC is having an EMS conference providing lectures to the EMS community. April 8th is the front line conference out at --

SPEAKER: April 5th.

DR. MURPHY: April 5th -- I have it written 5th. What did I say, 8th? Horrible. April 5th, is the front line conference.

Do you want to mention a couple words?

MR. STONICK: Ernie Stonick from Good Samaritan Hospital. April 5th is the Orange County EMS conference. We do it April 5th, Orange County 9-1-1 center all day, lectures, cardiac related. We have -- the fliers will

be out within the next couple days.

DR. MURPHY: Thanks. That is all I have down for new business at this point.

Under PAD Proposals, Epipen, Albuterol glucometry, I have none to bring forward today.

I have two Department of Health citations to add into the minutes.

Keith McCabe out of North Tonawanda, New York is suspended for one year effective December 15th. The suspension was stating he was assessed a civil penalty for violation of Part 800.

Melbourne Jones out of Freeport, New York was investigated and had a suspension instituted January 2014 through the May of 2014 for violations of Part 800. Those are the only two citations this morning.

That brings me to open forum.

MR. BENENATI: I went to a local chief's meeting in Pine Plains and the representatives were from the Amenia, Millerton, Stanfordville, Pine Plains and some others. One of the questions that came

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up is trauma issues. We are out in the boonies where five minutes -- five or ten minutes from Sharon Hospital and forty minutes to the trauma center. So technically they should go to the nearest trauma center, the problem is in 40 minutes the patients can deteriorate substantially. Most of all in these circumstances they call the helicopter, but there are times the helicopter is not flying and we are not clear what to do. Should they bring the patient to the nearest appropriate hospital, which would be Sharon, potentially, and then they make the transfer once the patient is stabilized? They are afraid they will be in violation of protocol if they come to Sharon Hospital and want me to ask and clarify. There are circumstances -- for example, the prior discussion -- traumatic brain injury, someone may have their airway protected and drop their pressure and in 40 minutes a lot happens. They are concerned if they go to the nearest trauma center the patient will deteriorate. And on the other hand they want

to be clear if they decide to make the trip to Sharon Hospital they wouldn't be violated for violating protocol. They want to raise that issue and clarify for them --

DR. MURPHY: Sure. And people can speak up, you know, at anytime.

Basically what you want to do is, one, take them to the closest facility if you need airway support and things like that. You want to stabilize the best you can. If the transport time is so prolonged we first would say, you know, institute the helicopter when they meet that criteria, that's for sure. Sometimes they can't fly.

I don't why, Dr. Stuhlmiller, you just won't fly all the time.

No, joking aside, you have to be able to take them to the closest facility, stabilize them to the best and get them to the trauma center as soon as we can. That was the initiative behind Lee Burns asking we look at all the trauma care in our area.

But, again, no one would be faulted for taking care of their patient stabilizing to

the best they can. If Sharon is the closest hospital and they need help, that's what they do. They can't drive two hours to get somewhere and the patient run into trouble.

So they are definitely supported. And it's a thing where a case by case basis it should be handled by their medical director and every case looked at, but absolutely no one would be faulted by, you know, doing that appropriate --

MR. VIOLANTE: Just to sort of go off from what he is saying, this maybe an issue also, where they are very far from ALS because they are in a rural area. And so this comes back to REMAC where we are becoming more and more involved in BLS components of care especially in rural areas as a component of what we do.

DR. MURPHY: Yeah. I think we have never been an extension of BLS and just at the ALS level and that's what we are opening up to now and trying to get out to all areas to open up our resources, our integration to the BLS agencies so that we all are on the

same page and we all are doing the right thing for the patients. Because like David says, I'm going to Sullivan County tomorrow, there will areas of -- up there it's just amazing the square area that we cover and that there is these places you are very far away from resources. So we have to do the best we can and, you know, take them to the closest facility, get them stabilized and launched as soon as we can.

One of things I think helps -- and Dr. Berkowitz, tell me if I'm wrong -- is to talk to them early. Talk to them right away, early, bam, this is what I have from our institution. Because, you know, let's not waste so much -- it's not a waste, that's really not the way to say it -- let's not spend so much time doing a million things when we can talk to them and say this is what we have. Because they are going to do scans and things like that that are vital at their institution that might even be repeated so we might be spending that golden hour or those golden minutes to do things that we may not

have to do right away and maybe when they get to your institution you can launch the helicopter there. So there are different ways to look at it, there is no steadfast. So we need to make sure we take care of the patients. And, you know, by far some of the BLS agencies out there, we are here to try and support them and help them as best we can.

And that brings us to another very important point of all the BLS having a good strong medical director to help them to review the cases, to support them, educate them. I think we all can do a better job at educating everyone and sharing information and that is what this is all about.

MR. BENENATI: I'll pass that on.

DR. BERKOWITZ: And I agree with you, as soon as you realize the patient -- your facility lacks the ability to care for that patient, that's the appropriate time to start trying to transferring them. Because waiting for other imaging to confirm you have something that you can't care for them

doesn't do anyone any benefit. But it doesn't mean you can't get the studies because sometimes the transfer process takes time. So you start the process as soon as possible and -- first of all, if you ever have issues, especially with a clinical patient, any of you guys can get in touch with me. We are continually trying to make the process as effective as possible. And, you know, once you are in the situation you can start the process assuming you don't have to be at the patient's bedside that second, just to get things going and if -- you know -- I mean -- you know, and we have it setup so -- for example, last Saturday night there was a call, no one could pickup the call so I got the call at four in the morning and started the process going just so that -- that patient was in the community hospital, had really no support, no blood, nothing -- they can start moving the patient because waiting for anything wasn't going to do anything good for that patient.

And I agree with what you said before

about the airway part, which I think that's the key thing is that you can't transport an unstable airway.

DR. MURPHY: That's a definite. That's in all protocols that if the airway is at any bit of risk --and it's in your aerial and flight protocols -- they have to go to the closest place to get the airway stabilized and get them launched.

MR. BENENATI: And that's the way we operate is stabilizing the patient and getting them moving because it's really to the patient's benefit to get to definitive care if you will. And, in truth, the transfer numbers are very helpful if they can get that --

DR. BERKOWITZ: Yeah, as soon as we -- like I said if there are ever issues that you -- just let me know because I know how important it is that -- that -- I think it's very important that the community hospital should be able to start the process as soon as they feel they need it. That's, you know, when you feel you need it and when you feel

your institution can't take care of the patient anymore, that's the beginning for me. And -- you know, yeah.

DR. MURPHY: That's called the launch button. The other thing it's Plain View -- right -- Plain View --

DR. BROOKS: Pine Plains.

DR. MURPHY: Pine Plains -- they are also in proximity to St. Francis, which is like Gary was saying before is there as a level two. And so we have these resources we have to just make sure we utilize and get them to the appropriate destinations.

DR. BROOKS: You know, we just want to caution, airway, depends what you consider stabilization. You know, if it's little bit hypotense and it's a matter of 10 minutes more to get to Saints, some parts of Dutchess County it's not so difficult to get to Saints. They have the code 99 and they descend upon the patient, which is the patient's best interest without first making a pit stop. An airway is different. You can't live without an airway, period, bottom

line, there is not a question about it for any of these patients. Which I think they have to be careful who they are going to, first bring to Sharon, and what is considered stabilization and who they can get, within what Gary? Thirty minutes? Some of these places are only thirty minutes. Where you maybe able to squeeze by and get the definitive care right there. You may want to --

DR. BENNEK: If there were ten or fifteen minutes difference I think I agree. But if you are in Amenia or some parts of the other side, eastern portion of Pine Plains, if you are on the far end of Pine Plains you are 10 minutes to Sharon Hospital.

DR. BROOKS: How long to Saints?

DR. BENNEK: Something like forty --

DR. NEIFELD: -- if there is airway issues or the patient is unmanageable from a head injury and having that patient in the back of an ambulance for half an hour to get to our shop versus five or ten minutes to get to Sharon, I think that's reasonable. Or if

there is major blood pressure problems, get them to the closest place, pop some lines, intubate them, call us or Westchester and get them out of there.

If they are injured, but maintaining, airway is good, blood pressure is reasonable, I think it's probably in the best interests to get them to the closest trauma center. And probably a good thing to tell the medics is, you know, just call the doctor at Sharon and run it by them.

DR. MURPHY: Yeah, I think medical control and the whole thing of discussing with the physician right then and there is available. When you have somebody with a significant, you know, mechanism of injury and, you know, falls into those criteria of traumatized patient we need to get them to that -- did you want to --

DR. CORNELL: No. I think some of the issues were bought up RTAC and it was discussed one of the projects for prehospital care is evaluating what is going on as a snapshot and look at the variable data we

collect to see if there are certain groups of patients that fit into transfer directly as long as the ABC's are under control.

The other thing is, they mention something about Facetime and trying to implement something in the media --

DR. MURPHY: Oh, my God, can you imagine? This is the patient --

DR. CORNELL: It was definitely discussed at RTAC and it is that project, Dr. Marini --

MR. BENENATI: The question is why aren't we doing that -- it's amazing really. We are one of the closest folks, it's been there a long time. I think we need to be careful in the message we send to BLS providers especially in saying it's okay to divert or go to a closer facility. Because I don't know that that is always in the best interests. And certainly I don't think that it follows New York State protocols as well as ours. We are really saying that these patients need to get to a trauma center, or certainly in the case of cardiac they need to

get to a PCA capable facility within a reasonable amount of time and it's worth that trip.

The second thing that I wanted to say is we often times talk about the capability of helicopters and, you know, how long does it take for us to get one to the scene versus if we have in the air. And I don't know -- and I'll certainly turn the floor over to Dr. Stuhlmiller -- I don't know why we are not diverting a ship that's already in the air to a facility we are going to. So if I launch a ship in Amenia and I don't want to wait for it, but I'm going to go to Sharon, why am I not sending that ship directly to Sharon? Then they are ready. We need to keep the patient's best interests here and same thing with St. Francis, we know we have a critical trauma patient, a pediatric trauma patient especially, where they are probably going to ship it and we have got it in the air why are we not sending -- and both arriving at the same time or getting there maybe a few minutes before the helicopter, so maybe you

can talk about that capability?

DR. STUHLMILLER: Certainly there is an ability to have the aircraft launched heading in a direction and then divert to another location. And traditionally in New York we don't have predetermined landing zones, but many places in the country there are secure predetermined LZs, that's where you go to when you have a patient in the community in that area. So certainly you can start to drive and the patient can begin to get care in the hospital and then the aircraft can land.

Now, you are talking about designing a real sophisticated system, which we are slowly moving to in medicine, to where health care delivery is catching up to the reality that health care is a continuum of care. But even here today we are talking about how we don't direct BLS, we don't direct interfacility transport. And yet it's somewhat of an artificial divide to say we don't do that because we all do that in health care. We are slowly moving our

structure toward that. If the helicopter were to land at a hospital and help take care of the patient, absolutely, that's what is best for the patient. But then as a system we have to stay where is that person going to go? And that should already be determined. It's not already determined. And so those are the sort of continuum of care system mindedness that is necessary.

If you are going to do an interfacility transport, who does the transport? What protocols or patient care guidelines do they follow? Who is the medical control for the interfacility transport? None of these things are worked out. And so if -- there is a tolerance for letting other groups decide what you are going to do, that is what has to be overcome before we can then design the system.

We are very happy to be involved in that. We already do that. And we have different capabilities then ground ALS does. In part it's because New York State doesn't regulate us because -- they don't. And so we

have patient care guidelines where we can start a unit of blood if we are handed a unit of blood. So there is a lot to improve the overall system that would make sense for the population and as health care moves to population health these things will work themselves out.

DR. MURPHY: One second -- just a clarification, whenever these guys do interfacility transports they definitely can call medical control so they have that as a backup. But if was before your regional medical advisory committees were not given the jurisdiction over interfacility transports because it wasn't under the same -- where prehospital that's where it was a sticky kind of point.

But you are right, things are changing.

MS. DOWNES: Just a couple things on this issue. I think, first of all, those agencies in the Harlem Valley that I think are creating some of these challenges is that if they have a medic on board I think as paramedics we are much more comfortable

taking many things to Poughkeepsie from that area than BLS provider without an ALS agency intercept. So I think sometimes that will make a difference in the destination. I also think that there is more than just the trauma protocols or the cardiac. It's trauma, it's cardiac, it's stroke and it's psych emergencies, those are the calls. I would like -- personally I would like to see a message go to the BLS providers that those calls that are not as high acute calls that they actually do need to transfer them to the proper facility, which would be Poughkeepsie depending on what the call is, even if you don't have the ALS provider there to do that intercept -- to take that call for you. Because right now what they are doing is really looking to Northern Dutchess to take their patients for them because they don't want to go take a BLS call to St. Francis or to Vassar when it's appropriate to do that.

So I do think that that is an area that is gray right now. I understand that they are volunteers and they might not want to be

out of service for that long, or have a call take them two and a half hours and that's difficult for them, so there has to be some way to balance that for the BLS providers. I think that's where the area of concern comes from. As far as I'm concerned as the medic I pretty much go wherever it is I need to go as long as I get the patient there safely, that's not such a big deal, but it's a really big deal for these BLS providers.

DR. BROOKS: We are going to be having a Dutchess County MAC meeting at the end of the of month and I think we have now brought Dutchess County in at the Council meeting. And I think maybe we can bring it up there and start looking into this if it's become such an issue with the BLS providers. I would just hate to see a patient going to the wrong place. You know, if I didn't have trauma facilities at Vassar -- we don't and we have more than you do -- but we are not set up, we are just not set up. We'll go, oh, my God, if somebody walked in the door or gets drove in by car and the first call goes

to Saints, but if you really don't have the backup it's really frightening. So I would hate to see patients have to take time and make a pit stop when they may not need to. Sometimes they do, but when they may not need to so perhaps we can bring it up at the MAC meeting -- Dutchess County MAC and EMS Council meeting and kind of hound it out --

MS. DOWNES: If there is some way to make sure those Harlem Valley EMS providers end up at the meeting that would be great because I don't think they are well represented there.

DR. MURPHY: Where is it?

MS. DOWNES: Right --

(Everyone is speaking at once.)

DR. BROOKS: Maybe we will have Dr. Bennek come and have input because that is definitely part of our county -- a date to be determined we'll do it. I'll get a hold of you because you are over there and you are involved with these people. I mean Amenia is right there, right there, as are other areas. So perhaps we will make this a project for

us.

DR. BENNEK: I appreciate that, thank you.

DR. MURPHY: Mike?

MR. BENENATI: I certainly heard what Andy was saying and I heard some things between the lines as well. So just to summarize the conversation I would say the message that needs to go back is unless the patient has an unstable airway or cannot survive the trip to an appropriate facility that is designated by DOH guidelines the patient should be going to the appropriate facility, which may not be the closest facility. And, you know, certainly that is your decision to stress, but that's the message I heard here.

DR. MURPHY: Yeah, I mean, I think BLS always has to abide by the DOH guidelines that they have, that's who really, you know, determines what happens at that level. However, it's our -- we are challenged with the ability to provide good care in our region. This is our responsibility as the

medical directors and physicians of all the hospitals in this area, is to make sure we have a system that delivers the care, protects the patients and gets them to the right destinations for their care.

Trauma, you know, definitely being worked out now. People are getting trauma designations, people are upgrading trauma designations, and so there are things in flux at this point. However, you know, I think the message has to go back that, you know, we support them, we get them the resources to provide that care. And, again, I go back to having every BLS have a really supportive medical director and ability to call into medical control. You know, it's a thing where you can call and talk to a doctor, ask them, you know, let's have a conversation here, what we have in the back of this bus and what we need to do.

David?

MR. VIOLANTE: Just to clarify again, this comes from the DOH from Andy Johnson at the State our collaborative protocols now

supersede DOH BLS protocols. So, again, this group again is responsible for that subset of personnel in the field.

DR. MURPHY: That's why I'm getting out there to try and talk to all the BLS providers so they realize this is an extension, another extension, and we are all in this together and that we all work together, again, you know, to provide the best care we can.

David?

DR. STUHLMILLER: There is a field triage of injured patients that has been revised by the American College of Surgeons now published through the CDC. And the most recent version has guidance to prehospital providers to where to deliver a particular patient. So if you have physiological criteria of trauma you go to the highest level trauma in the system, anatomic criteria then you go to the closest trauma center, preferred highest level, and if you have mechanism criteria then you go to a trauma center or the closest hospital. And the

difficulty is when do you decide to go to the closest hospital as opposed to go to the trauma center? Just what Dr. Bennek asked. And that is a different answer depending on what the patient has and a different answer depending on your local resources. And how do you define local changes the answer. If you look just in Dutchess County you will find a different answer than in the Hudson valley, or State of New York, or nationally. So you have to decide at some regional definition what we are going to do in this region and agree. And that's where you are asking, Mike, that's where it really gets to be a comprehensive across many disciplines open discussion as to how are, quote, we going to do things in, quote, our region? And if the RTAC is going to lead that discussion and just not answer the question, but gather all the people individually that represent different entities within the overall delivery system, then maybe you can answer that. So the answer will be every patient comes to Sharon if they are within

five minutes and then Sharon does these few things to identify if they can stay here, they need to go, and then someone is going to transport and to where is already known. So that's not today, but if that is going to be built for the RTAC we will certainly be involved in the helicopter EMS world in these discussions.

DR. CORNELL: Just I think all these things that come out from an ACS Commission on Trauma CDC, they are all guidelines. The patient doesn't read the guidelines, so you have to at the end of the day evaluate the patient. And if the teaching is if the patient is unstable, you don't have the ABC's transfer to the nearest facility to stabilize the patient, stabilizing the patient will be dependant upon that facility. It may just be intubating them, hanging a bag of LR and getting them out of there.

Having said that, if you have all these committees and REMAC and REMSCO and, et cetera, et cetera, they exist because 90 percent of the patients do fit into

guidelines you can follow, which is best for the patient. There is probably 5 percent, 10 percent range of where the patient doesn't read the guidelines, doesn't follow it and that's where you have to take your professional training and do the best you can and no one is blamed for that, ABC's always come first.

MR. BENENATI: And I think it's very important, as Dr. Stuhlmiller said, we need to look at the CDC chart. If you read every word on that chart there is a very important message with regards to transferring patients. I'm really not sure most people haven't just flipped it thinking it's the same as the old and it's not. It reads completely different than New York State traditionally used and that's the chart that the bureau is now using and certainly that is present in the collaborative protocols as well.

DR. MURPHY: Right, I mean, it's definitely different. I think where we are challenged with and what our responsibility

is for this region is to take all this information, but we make the decisions. So all this information has to funnel back from the helicopter committee, from STAC, from RTAC and we bring together and sit here at this table -- and I'm really thankful everyone is here today -- and have these discussions and this is where we come up with, let's make some destination decisions helpful for our area. Is it going to perfect? Never. Because we have such various ranged areas from the depths of Sullivan County to, you know, Dutchess County where, you know, people are six minutes between the two. So it's different. However, I think we are challenged with that decision to make for our patients and be the advisors so the area and help and support both from BLS level to an ALS level. And this is the first baby steps and hopefully we are going there, but that's the goal.

So I need all your help, okay?

DR. LARSEN: There is also a -- you know, figures into this whole thing and I

think it's figuring into a lot of the thinking here is there is a fairly good study came out of Canada that basically showed that trauma patients arrive just as well with BLS as ALS to -- you know -- to definitive care. So that I think plays a big thing in -- certainly there is that decision, do they need a helicopter --

DR. MURPHY: Airway is the only --

DR. LARSEN: -- need helicopter you know to get the patient to definitive care as quickly as possible? Once you have gone beyond that do you need -- does this need to be an ALS or BLS decision? I think they can keep going.

DR. MURPHY: Any other comments?

So, Craig, do you want to be a head of that committee -- no, I'm kidding.

DR. VANROEKENS: I'm not --

MR. LAMARCA: You are not defending yourself.

DR. MURPHY: Oh, Dr. Shah is --

(Everyone is speaking at once.)

DR. MURPHY: Anything else for open

forum?

MR. LAMARCA: Just one thing, maybe more educational, it's back to the collaboratives for a second. We have had some problem getting physician signature after a call. And just as a reminder, in the protocols or policies Section 11, as far as record keeping policy really calls for after the call is done that we need the signature of a medical control physician even on standing orders. Some of the physicians thought that was not the case, it was just on active orders, but it's on all. And we worked it out at those hospitals, but you may want to remind the medical control physicians.

DR. MURPHY: Yeah, I think it goes even beyond a signature. I think the interaction, the call review, the report, you know, we need to take the time and do that. We need to take the interface to sit there -- not sit, hopefully you are standing -- and go to the bedside with the provider and go over the case and sign off on it. And I think this is what this is all about. It's that we have

that communication because that is where we learned about what happened at the scene, that's where we learned about what is going on with a patient and that's so valuable. I think that goes without saying if we want people to -- all physicians to integrate and work with the agencies and sign off on the care. And I think that's very important. That exchange of information -- you know, where does litigation of problems happen in medicine? Turnover of care, change of shift, you know, from one level of care to another, from one institution to another, from one doctor to another, from one provider to another. So any communication is very important. And what was emphasized in the protocols was we go there and we sign off on the patient, we sign off, you know, on the electronic PCR and -- you know -- have that exchange of information forthcoming and streamlined. Does that help?

From God's mouth -- no.

Okay, anything else?

DR. BENNEK: One more thing, people are

starting now to asking me about signing off on intranasal Narcan. I don't know exactly what the protocol for getting that done for each individual squad might be. Can you clarify now or get me information --

DR. MURPHY: Not a problem.

DR. BENNEK: -- cross T's, dotting I's --

DR. MURPHY: You got it. There is a whole way to apply to become an agency to use it. They have it already in a packet format here. Bill can sit down and show you a little bit, but they can send you the whole electronic packet.

Just like how we applied for other interventions there is a, you know, way for you to have the agreement with your medical director, the educational process, the QI process, the ability to educate, administer and constantly review and provide this office with the information of when you use it, that's all setup. He has a whole packet for you and can --

DR. BENNEK: They may have covered it

all, but I wanted to make sure.

DR. MURPHY: Yeah -- no, not a problem. That's definitely done, it's in format and such.

Actually, you know, just that segues into, you know, the whole thing of them giving Narcan to family members now. That they are getting that out there and that's why it's become such an issue of there has been an amazing amount of saves in the literature if you look at from family members administering Narcan. So it's a sad thing how cheap heroin has become and how ubiquitous its use is, but this is what we are doing.

MR. LAMARCA: I heard State Police are going to put on a couple units --

DR. MURPHY: Yep, State Police are going to do it. Yeah, it's amazing, but it's out there.

Dr. Mao, you are so quiet. Any comment?

DR. MAO: No.

DR. MURPHY: Okay. Anything else?

Thank you all for coming. Motion to

Proceedings

adjourn?

DR. MAO: Motion to adjourn.

DR. MURPHY: And a second?

DR. WILSON: Second.

DR. MURPHY: Thank you.

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

Yvette Arnold