----------x

HUDSON VALLEY REGIONAL EMERGENCY

MEDICAL ADVISORY COMMITTEE

----------x

MINUTES OF MEETING, held at the offices of Hudson Valley Regional EMS, 103 Executive Drive, New Windsor, New York, on Monday, June 2, 2014, at 9:30 a.m.

Yvette Arnold,

Court Reporter

ROCKLAND & ORANGE REPORTING

2 Congers Road

New City, New York 10956

(845) 634-4200

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

DR. PAMELA MURPHY, Committee Chair

DR. ERIC STUTT, Medical Director

WILLIAM HUGHES, EMT
Executive Director HVREMSCO

JEFFREY CRUTCHER, QI Coordinator

BON SECOURS COMMUNITY HOSPITAL
DR. CRAIG VANROEKENS,
Physician Representative

CATSKILL REGIONAL MEDICAL CENTER

DR. VOHRA,
Physician Representative

GOOD SAMARITAN HOSPITAL
DR. DENNIS MAO,
Physician Representative

HUDSON VALLEY HOSPITAL

DR. EVAN COHEN,
Physician Representative

NORTHERN DUTCHESS HOSPITAL
DR. WILSON,
Director

NYACK HOSPITAL

DR. MARK PAPISH,
Director

DR. SACHIN SHAH,
Physician Representative

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

ORANGE REGIONAL MEDICAL CENTER

DR. DAVID CORNELL,
Physician Representative

PUTNAM HOSPITAL

DR. BUTTERFASS,
Director

ST. ANTHONY COMMUNITY HOSPITAL

DR. ERIC SILVA,
Physician Representative

ST. FRANCIS HOSPITAL

DR. GARY NEIFELD,
Physician Representative

ST. LUKES CORNWALL HOSPITAL

DR. SCOTT HILL,
Director

WESTCHESTER MEDICAL CENTER

DR. JON BERKOWITZ,
Physician Representative

WESTCHESTER REMAC LIAISON

DR. ERIK LARSEN,
Physician Representative

ALSO PRESENT

DAVE VIOLANTE
ANDY LaMARCA
MIKE BENENATI
MIKE MURPHY
ANDREA NELSON
ERNIE STONICK
STEVE ANDERSON
ANDREA DOWNES

Proceedings

DR. MURPHY: So I'll bring the meeting to order and ask for a roll call.

Eric is here.

Francine Brooks?

Dr. David Stuhlmiller?

Dr. Craig VanRoekens?

DR. VAN ROEKENS: Here.

DR. MURPHY: Dr. Carlos Holden?

Dr. Vohra?

DR. MURPHY: Dr. Dennis Mao?

DR. MAO: Here.

DR. MURPHY: Dr. Ron Nutovits?

DR. EVAN COHEN: Here.

DR. MURPHY: Dr. Fareed?

Dr. Cohen?

Dr. Wilson?

DR. WILSON: Yep.

DR. MURPHY: Dr. Sabia? Just sometimes he comes too, but I wasn't sure.

Dr. Papish?

DR. PAPISH: Here.

DR. MURPHY: Dr. Plexousakis or Santikul -- so I guess it's going to be Murphy.

Dr. Butterfass?

Proceedings

DR. BUTTERFASS: Here.

DR. MURPHY: Dr. Dittmeier?

Dr. Roshe?

Gary, I saw you come in.

Dr. Hill?

Dr. Roberson?

Dr. Bennek? I thought I saw him.

And Dr. Ajbani or Francine -- is Frannie coming today?

Are you representing Dittmeier --

DR. SILVA: Yeah.

DR. MURPHY: Dr. Eric Silva representing St. Anthony's.

DR. LARSEN: Dr. Murphy, Dr. Cornell is here from Orange Regional.

DR. MURPHY: Excellent. You told me you were coming David.

DR. CORNELL: I did.

DR. MURPHY: There is the list.

Okay, first item is to review the minutes from last meeting. And does anyone have any deletions, corrections, substitutions, anything they want to change or amend?

Proceedings

Did everybody get a copy of the agenda? She sent it electronically. I have some more if we need to send it around.

Can I have a motion to accept the minutes as is then?

DR. WILSON: I move.

DR. MURPHY: Can I have a second?

DR. STUTT: Second.

DR. MURPHY: So moved. We will accept the minutes.

We will move along to old business.

Just an update with the collaborative protocols. With BLS we mentioned it the last time that we have been going around and having meetings at each kind of county wide distribution, we did two in Orange County, we did one in Rockland, one in Sullivan, and one in Dutchess. And we have one to go in Ulster, right.

DR. STUTT: Putnam we will do in June.

DR. MURPHY: And then it will be complete. What we did was go around and make sure everybody realizes BLS is now included in our protocols that we have made and joined

Proceedings

in the process and make sure that we go through each one of the protocols where it's so named and some of the changes that have occurred and some of the things that are there for BLS to institute in terms of treatment protocols ahead of ALS arriving. Namely, you know, the asthma protocol, the helping a patient with their aspirin or nitro and such. And it's been received well. I think that, you know, we were worried initially that what would be the people's response and the BLS audience and it was really good. I mean, I have to say it's all come together very well. And I think that they are finding and realizing more and more they are all part of the same team. They usually happen to be the first person on the scene, but it's an extension of the hospital and us seated here in the emergency departments, we are all in this together.

Any comment from the collaborative committee, anything? Anybody?

The other thing in terms of collaborative committee I'll say on the

subject right now, they are looking and asking for people to go on the website and put in any suggestions, any ideas, any thoughts, any modifications, anything you guys see in the protocols that you would like to change, update, modify. They are already doing an amazing amount of interpretations and changes, but we just love to have input. We are going to have another meeting --

Oh, Dr. Vohra is here too.

We are going to have a meeting June 5th, after SEMAC. So we are talking about a bunch of issues and I think that, you know, no idea is too small or too big. It's all good stuff. We continue to move on and continue to improve things in our region and our input is extremely important because we get a different sense from the other portions that are in the collaborative protocols. So it's extremely important that we keep our finger on the trigger and keep things moving in that direction.

Andy?

MR. LAMARCA: I was going to the website

and put in -- talking about use of CPAP for smoke inhalation cases getting started in the field. Is there any objection to us asking the collaborative to look at that? Okay.

DR. MURPHY: Yeah. I think one of the things that is important with all the protocols we are doing and everything that have added on is we are moving a lot towards these kind of noninterventional procedures and we are moving with nasal administrations and, you know, CPAP has a lot of indications that we could use.

And one of the things that they are looking at right now is to really improve the pediatric side too. A lot of what we spent the last meeting was looking at all the pediatric protocols and revising, making sure they are all up-to-date. Every single one will have a weight based administration of medicine, but will have a cap. Before we just said one milligram per kilogram or whatever, but we never put the cap. We have to put the cap because as you know if the kid is big enough they are beyond the adult dose

Proceedings

so that has to be in there. So that's one thing that has already been added.

DR. STUTT: Andy, regarding the smoke inhalation, would that be all or just those in respiratory distress and if they are in respiratory distress they already qualify.

(The speaker cannot be heard.)

MR. LAMARCA: -- realizing that if we get them on oxygen, particularly oxygen under pressure it will help to provide that carbon monoxide.

So I just want to throw this out for decision. If they want to amend a protocol a little more specifically, but now it's not that specifically addressed --

DR. SILVA: -- 100 percent oxygen I don't know that you necessarily need CPAP. It's not going to deliver more than 100 percent, if they are not in respiratory distress I'm not sure it would be indicated. The other thing is in smoke inhalation, it's fire, we need to be careful that it's not upper airway injury strider proceeding to respiratory failure. So that's also a

Proceedings

concern.

MR. LAMARCA: I know it's being used in other areas of the country --

DR. MURPHY: I think it just has to have clear cut indication, but it's not for everybody for sure.

Any other comments or concerns?

Service upgrade. We had New Windsor that took the paperwork -- anybody here today with any kind of more information on that? No? So I guess they haven't brought it -- they have the paperwork out -- not New Windsor -- sorry, Town of Wallkill. They have all the paperwork and everything in their hands, but we haven't gotten everything completed back so until we do then we will form a TAG and move the process forward, but right now that's the only upgrade pending.

Evaluation subcommittee? No issues?

DR. STUTT: Nothing.

DR. MURPHY: Helicopter committee report. Dr. Stuhlmiller is not here. There wasn't a meeting, right?

DR. LARSEN: No, so we are good.

Proceedings

DR. MURPHY: Thank you, Erik.

Quality improvement. Go ahead, Jeff. And, Jeff, I have a couple things to add at the end.

MR. CRUTCHER: All right. Year-to-date for internasal Narcan applications 34 are in, 24 are approved, with that there have been five documented saves, three from Kingston Fire, two from Pleasant Valley.

PAD applications, year-to-date, six, five have been approved.

BLS glucometry, year-to-date, thirteen, eleven have been approved.

The trauma study is progressing well, all data gathered, studies being written, about 80 percent complete on that.

We did a documentation training on May 12th with the Northern Alliance agencies that went very well.

Website, continues with updates. The usage for the website is up 41 percent over 2013. And that's it.

DR. MURPHY: Two things, David, do you want to talk a little bit about the nitrous

process -- the QI study?

MR. VIOLANTE: We did a retrospective study of nitrous oxide use among four agencies to be inclusive into the collaborative protocols because it's not there now, a two-year study with Arlington Fire, Shandaken Ambulance, New Windsor VAC and Ellenville First Aid Rescue Squad. We knew anecdotally and empirically it worked, now statistically it's proven this works -- there you go. We had a total of 41 patients that it was used on with a greater than 50 percent reduction in pain. In most patients it was -- in patients -- sorry -- 81 to 100 percent with the greatest number of patients that experienced a reduction in pain. And all the statistics came back well so this is going up to Dr. Dailey --

DR. MURPHY: Yeah.

MR. VIOLANTE: -- to be included in the collaborative protocols as an option for pain management for agencies that wish to use it.

DR. MURPHY: Yeah. What happened was, as you know, our protocols before always had

nitrous for those four agencies he talked about, which you mentioned there. And it was not part of the collaborative protocols, no one in their region uses it. So what they asked us to do is come up with information to prove that it works in our agencies and how we have used it, utilization, what kind of uses we are using it for. One of the agencies specially uses it for long bone injury and such, they work out of the ski facilities -- yeah -- and for dislocations and such. But what they wanted was, could we come back with some data on it so that we could prove it to the entire committee and actually to bring it to SEMAC too. So that it's included and we added onto the protocol as a pain management modality, so that was the process behind there. And I'll bring that first edition up to SEMAC.

We are going to start another QI study, which I have under new business so I'll wait -- well, actually we can talk about it now.

Under new business you'll see pit stop CPR and I'm not sure if people have been

reading about it, been hearing about it. But it's a high performance CPR mechanism such that when we have people respond to a scene we have actually like a pit crew respond, a numerous number of people. So that we exercise high performance CPR, meaning it's incredibly consistent, well done, we make sure people are doing it extremely perfectly. And I swear to God we have a model here and I'll turn it over to these guys in a second to guide people. And what it does is you rotate compressors so quickly, that's why they call it pit stop CPR, and it's only going to work where you can have a large number of providers respond. So it's not going to work for everyone. However, it's shown in other areas of the country to work extremely well and to be very successful with a higher ROSC survival, so it's an interesting concept. We want to try and keep things going, keep ahead of the page here. And this was brought forward by Matthew Brennan and I would like to turn it over to them and Andy LaMarca right now to speak a

little about it.

MR. LAMARCA: As Dr. Murphy pointed out, largely this is due to Matt Brennan's diligence. He is our critical care coordinator and one of our QI coordinators. He's done the research on this pit stop, you know, CPR, as you call it, or high performing HPCPR. And I think what he said is we just moved into a whole series of monitors, which gives us monitoring capability we didn't have previously -- I'll let Matt tell you about that.

In our service area we looked at one particular example where we feel confident we could do this study.

MR. BRENNAN: Good morning. We are actually look to develop this protocol and looking for guidance from the REMAC to get it up and off the ground.

What we are looking to do obviously is improve the ROSC numbers for subcardiac arrest victims. The focus group we decided to go with is in the Town of Ulster in Ulster County. The reason for that is our ROSC

numbers currently are not terrific. In numbers from last year we are about 9 percent versus 42 percent in the City of Kingston. And we feel that the reason is when somebody suffers a cardiac arrest out there that it is dealt with as a trauma case. Let's get the of patient up off the floor, onto the stretcher and into the hospital.

What this type of CPR focuses on is a type of high quality compresses, de-emphasizing ACLS, focusing on the compressions, delivering at least 100 per minute, switching providers rapidly. Actually, Andy brought up the new monitors, the Zoll-X series monitors, where we can do a calculation of the quality of CPR being done. And just from brief trials with our own paramedics we found that two minutes of continuous cardiac compressions is way too much for any single provider. So the focus of this is to actually switch at one minute or one hundred compressions. After those two cycles of two hundred compressions or two minutes that's when the rhythms would be

analyzed. The EMTs that are out in Ulster will be trained to perform this type of CPR, to work in the pit crew mentality. So when we arrive at the scene of a cardiac arrest we are focusing on doing the arrest, not in getting a patient directly into an ambulance, not moving immediately into the hospital. The best chance of survival is within minutes of the EMS arriving.

We also found through studies that even with the best diligence, fifteen to two, we are only achieving cardiac compressions about seventy percent of the time, which is obviously not enough for somebody suffering cardiac arrest.

Airway control is going to be done primarily with the KING airway, secondary to the fact that we don't have to stop CPR to insert the device. If we can't insert a KING airway and if the paramedic is confident --

(The speaker cannot be understood.)

MR. BRENNAN: Primary IV access is going to be intraosseous. Once again to keep the provider starting the access out of the

action of providing cardiac compressions and to get the ACLS medication on board.

Anybody have any questions?

Is everybody familiar with the concept of this high performance pit crew CPR--

DR. LARSEN: How about in all this is there any use for machines?

MR. BRENNAN: We do not have right now any type of road work for any type of automated CPR device, not currently. The price constraint on those unfortunately is too high.

DR. MURPHY: People have it for those long transports and intra facility transports and some specialty care stuff, but I think it's hard for certain agencies to be able to afford the numbers and all of them are pretty expensive. Yeah, but we are going to use manpower --

MR. BRENNAN: We will put a lot of stock in the BLS providers that are on-call. The nice thing about the cardiac monitor we are using now is actually in front of the provider you will be able so see their

Proceedings

quality of compressions --

DR. MURPHY: It's pretty amazing --

(Everyone is speaking at once.)

MR. BRENNAN: -- rate, depth and release and then there is something called a performance --

DR. MURPHY: PPI.

MR. BRENNAN: -- PPI, which is essentially an indicator, a box lights up consistent with what they are doing.

DR. BERKOWITZ: Which model of the KING will you use, the one with a port to put a gastric tube in or --

MR. BRENNAN: Yes.

DR. WILSON: Matt, you quoted nine percent survival rate in Ulster, what N is that, how many people --

MR. BRENNAN: One out of eleven.

DR. WILSON: So how many people are in cardiac arrest -- sudden cardiac arrest a year there?

MR. BRENNAN: In the Town of Ulster?

DR. WILSON: Yeah, versus Kingston? Because it's a lot smaller, isn't it?

Proceedings

MR. BRENNAN: Town of Ulster geographically is larger, but the population is not as dense. So when you think of Kingston you are actually thinking of the Town of Ulster, that is where the Hudson Valley Mall, all up and down Ulster Avenue where the commercial area is. So 11 victims in cardiac arrest that were actually not DOA, were not terminated, but brought into the hospital --

DR. WILSON: Are you guys --

MR. BRENNAN: -- versus 42 in --

(Everyone is speaking at once.)

MR. BRENNAN: -- 42 percent.

DR. WILSON: You know, I just was wondering because the numbers -- if it's more spread out, then you know the arrival times are going to skew all of -- it's a tough one to compare the two I guess.

MR. BRENNAN: Here is another thing that we did is relocated a station so we have a stronger presence so there is a 24 hour ambulance station there. And the other thing which made them kind of turnkey was there is

Proceedings

no need to change their response posture, they respond with their first responders in fire department flag cars and a rescue truck. They automatically come so we are going to get eight to ten people automatically without doing anything different. Versus the City of Kingston, we actually have to change their response posture.

DR. WILSON: Question, are you guys going to use N title Co2 at all?

MR. BRENNAN: Yes.

DR. MURPHY: Craig, did you want --

DR. VAN ROEKENS: Again, it's just the capnography.

DR. SILVA: What is the optimum number on the -- you mentioned one minute of CPR being sort of a max, you know, optimum, how many people are you getting in the back of the ambulance to continue doing CPR?

DR. MURPHY: This is at the scene --

MR. BRENNAN: We are going to put a time actually on this. And we are looking at anywhere from 15 to 20 minutes on scene without moving the patient, so no transition

for the first 15 to 20 minutes. The optimal number of the people would be seven. We would have one choreographing the cardiac arrest, you have one watching the cardiac monitor, you have two side by side ready to do compressions, you have another two controlling the airway, if we were at BLS level you have one holding CO and the other one squeezing, and the last person would be there to relieve whoever needed to be relieved.

DR. MURPHY: Well, right now -- this is why Matt picked this area -- right now they have all these people that respond so it was like a perfect setup to trail this. And so we will try and see what happens. And, you know, we will bring back statistics. I'm going to work as the medical director for this QI project. And it's just interesting, it's a new way -- I mean, American Art has already looked at this high performance CPR and started the process. So we want to see does it work? We want to do a small area that responds this way anyway, they made the

comment to bring in their new Zoll monitors. You know, we'll try it for a while and see what we get.

MR. HORTON: Ed Horton, Mobile Life. Another interesting comparison I think that we will see out of this, albeit folks, this is not absolute scientific work, okay? This is not going to come to the statistical bearing that a program would that if we had an IRB and controls that are better and so on and so forth. However, LaGrange has been doing this for some period of time now. They have been able to because they have the amount of manpower they can get out on every cardiac arrest call. So another interesting comparison might turn out to be how we are looking at it in a suburban area where we are talking about, but the population density is not quite like Dutchess County and so on. I think, again, even though it's not apples to apples to apples all the way through I think it will give us some idea how to sell things moving down the road. Certainly the presumption may well be if you don't have the

type of manpower available in a given area putting a program together like this may not be plausible right off the bat. But we can take a look at off shooting it -- unless we take a look and study it further I don't think we will know the answer.

DR. MURPHY: And it requires a significant time commitment because the front end education process is key and that's what is really going to make this work and make people function as a real pit crew team.

MR. BENENATI: Just two things I think it's important for the physicians to understand, that we really need to be operating on scene a minimum of 20 minutes. If fact, when we started looking at protocol last year I tried getting that contact medical control time down a little bit because that first 20 minutes is critical. You can't move the patient in that first 20 minutes, the only way to do effective CPR is to leave them where you find them.

The second thing, a little different that we have been doing, is we are trying to

set more paramedics on the scene and we have had positive results getting two or three paramedics working simultaneous ALS procedures at the same time.

And so we are going to really dovetail -- we haven't done an official study on it, what we have been doing, but this is our opportunity and we have been speaking with Mobile Life on this. But this is an opportunity to dovetail and look at a different component.

I also have spoken to Dave to see maybe if we even do an Arlington LaGrange team approach to increase the study area and make sure that we get two or three paramedics on each one. We have had outstanding results with this and I hope -- and we certainly have supported Mobile Life in this program -- again we are giving people an opportunity to get people resuscitated that haven't been in the past. And while -- sorry -- and the capnography plays a significant role with it, especially at the 20 minute mark. If you are less than 10 at 20 minutes there is not a

high chance of survivability and over 20 there is. At the 20 minute mark you really got to make a decision, do I invest another 10 minutes on being here -- those are the kind of decisions that are going to need to be made in the field that we need to look at.

MR. BRENNAN: And Dr. Murphy, you are correct it's going to require a lot of training --

DR. MURPHY: Yeah, it really is. But it's an exciting thing, see everything goes back to square one when we started. You know, that high compression CPR really does save lives. And if you look at the statistics and where they are doing it elsewhere it's been successful. But it's not something we can just implement like that, it's going to take some work and it's going to take some tweaking and some ideas and ways to improve upon it. But it's just very interesting -- Dr. Cornell?

DR. CORNELL: What is our average.

MR. BENENATI: We used to shoot for about 20 minutes, like Matt indicated, get on

scene, get them on a backboard, get them going. What we have seen, you can't do effective CPR trying to move that patient from the house to the backboard, stretcher to the ambulance. I have documented cases where you even rush to get them into the ambulance before you even start. And that's the stuff that -- that's the mentality that has to be changed --

DR. CORNELL: Do we have a number on it? That's what you kind of want to look at, right?

MR. BENENATI: Number on what?

DR. CORNELL: Starting a program, what is the average on scene time on cardiac arrest now you are going to --

MR. BENENATI: Yeah, you know prior to that -- and again we have 12 minutes or less.

MR. BRENNAN: I agree with Mike, same as our agency --

DR. MURPHY: Yeah, we can come up with a number. And he also has the numbers of ROSC now that they have. So Matt, that too would be interesting to see how long it's going to

improve scene time, but it's probably a good improvement.

MR. LAMARCA: I think one small point is the new series of monitors we don't have to stop CPR any longer to see the underlying EKG rhythm. So that leads to less interruptions and focus on the pit crew. The program is for two-year study.

DR. MURPHY: Erik?

DR. LARSEN: What is the on scene time Kingston compared to Ulster?

MR. BRENNAN: Transport?

DR. LARSEN: No. Arrival -- scene arrival?

MR. BRENNAN: From scene to arrival at hospital --

(Everyone is speaking at once.)

DR. LARSEN: The response time?

MR. BRENNAN: Our response time is only going to improve because we moved the station out there so we have a station in the middle of the Town of Ulster. Currently we shoot for 8 minute 59 second response time from the time of dispatch to the time we are on

patient scene. Historically we are on scene in the Town of Ulster anywhere from six to seven minutes after dispatch, city of Kingston will drop to five or six minutes.

MR. LAMARCA: Ulster Fire comes out --

MR. BRENNAN: And are usually on the scene in three to four minutes.

MS. DOWNES: My question is because the areas that you are talking about have pretty quick responses to the hospital from where your patient is likely to be located versus the area that I work in. And I'm wondering if we take into account that, you know, we still have potentially 25 or 30 minutes in the back of the ambulance going to the hospital --

MR. BRENNAN: Right, I think that's kind OF the crux of the whole thing, is within the first 15 minutes you are going to know -- like Mike said -- whether you are going to achieve a ROSC. We all know that it's next to impossible to perform effective high quality CPR in the back of a moving ambulance with the exception of an automated device,

which I don't think many agencies are in the position to purchase. With the bouncing you are not able to effectively perform that cardiac arrest, that's why staying on the scene for the extended period of time is the goal. If it takes 15 minutes to transport to the hospital you continue what you can continue.

DR. MURPHY: Andrea, good point. But that's is the whole nidus behind why we thought of this actually. And when you look at other areas -- we don't have the data here -- but where this all came from is they found where these long transport times by working on like the kind of golden hour in trauma is working on the people that have full cardiac arrest at the scene and giving them the 15 to 20 minutes of high quality CPR can we get more ROSC? And they have shown in other areas it is true. And that's why we are going to start here and see does it work for us? Is it something we can modify and bring to the area? Is it something that will help out regions where you are and where the

transport is long? But if you have ROSC back you can now safely transport, you can give medications that will hopefully maintain a good rhythm, and you can monitor their airway and bring them in with a pulse and a blood pressure hopefully when you get there versus transporting a person and losing that first golden 25 minutes that you can work on them. And that's why the change of kind of our philosophy and looking at it for full blown cardiac arrest.

MR. BRENNAN: We are going to have a lot of exclusion on the back end side of it as to who fits into the study and who does not and also on the scene. This is primary going to be for the sudden cardiac arrest victims, presumed cardiac, not presumed respiratory that would need more of an airway, oxygenation and the paramedic will make the determination on the scene.

DR. VAN ROEKENS: Okay, you looked at just witnessed.

MR. BRENNAN: We are looking at not just witnessed, but presumed cardiac.

Proceedings

DR. VAN ROEKENS: You have to differentiate the two.

MR. BRENNAN: Correct. And that is a lot of history, taking the interview on scene and deciding --

MR. LAMARCA: Just on the references, one of the first references is from the Resuscitation Academy and if you are going to that link we provided you will find it is broken into different aspects of the pit crew and all of those have individual references. If you want more information, that's a good place to start.

DR. MURPHY: Any other thoughts or questions? Okay.

DR. WILSON: Just one more -- sorry, I lied. Matt, are you -- are you just going to collect how many ROSCs you guys get or are you going to follow like how many had deficits or more of a global picture of is this really helping, great, we get a spontaneous return of circulation but these people functional after?

MR. BRENNAN: Yes. That's where the

Proceedings

disconnect always existed --

DR. MURPHY: It's hard to get that data the --

(Everyone is speaking at once.)

MR. BRENNAN: We are going to try and follow these patients through as far as -- because the goal is to provide, you know, perform a resuscitation with somebody who is going to return --

MR. LAMARCA: We have other discussions with the Health Alliance of Hudson Valley, the hospital that receives most of the patients. It's not an overwhelming amount of volume so we hope they go pickup and track some of the individual cases.

MR. BRENNAN: Some of these folks of Northern Dutchess ask the same thing. We try and follow them through.

All right, thank you for your time.

Any other questions?

DR. MURPHY: Thanks.

Under new business, the protocol committee got together and went over and have put out now the process for MFI for all

agencies who wish to apply for it. Can you --

DR. STUTT: We met about three weeks ago and the main purpose of -- well, main focus of the discussion at that time was how to broaden the expanse of who is going to be learning MFI and who is going to be certified to train it -- to do it, certified to apply as well as assist. Anybody who is trained can assist in MFI, only those certified after testing can actually use MFI. We are recognizing we want to apply it more widely throughout the EMS community in the Hudson Valley Region, that there is a very select group of agencies who are doing MFI, but their impact could be expanded if we had more people trained to assist them. Because the new protocols require two trained personnel there, one of those trained has to also be certified. So in the interest of expanding our abilities I'd ask Ed Horton to explain what the new training systems will be and how they will be provided to the community.

MR. HORTON: It was pretty much agreed

at the protocol committee that every agency that gets involved with providing MFI should have a paramedic level instructor on board with their agency for purposes of continuing to provide that instruction, quality improvements is a possibility, and the other substitute for that is the medical director for, of course, the given agency could also, you know, take this position.

So one of the things that was decided is that we are going to run a train the trainer type of program on September 17th. We are going to do it at Mobile Life's location. Again, not to pound chest too much, but we have been doing this since 1996, I think it is. We have a little experience with it in the prehospital setting, learn where pitfalls can certainly occur in that type of thing. So we have been asked if we would host a train the trainer for any agency in the region that is interested in coming in and getting some of their instructors up to speed on this. Basically it's probably going to be about a four to six hour educational process.

There is given amount of didactic, there is going to be a hands-on skills workshop, if you will. In years past when we brought people up to speed on this level we had to put it in the operating room with an anesthesiologist there. It's pretty much been decided that that is not as beneficial as it seemed to be on paper. Again, we are using some of the medications for the prehospital setting that the anesthesiologist had to makeup their mind, I guess I'll use succinylcholine, and decide that the clinical aspect of this wasn't meeting what we thought it was going to do. Essentially though that's what we are looking at setting up.

As far as the other qualifications are concerned, there's been a bridge of individuals who were RSI paramedics in the past, I think they have been brought over as MFI paramedics with associated paperwork to Regional office and so on. This is the program I'm talking about on the 17th of September is to begin moving forward so agencies now can bring their personnel up to

speed as they and their medical directors feel is necessary for them to meet the qualifications to provide the MFI service.

DR. MURPHY: And I think what I wanted to emphasize, what Ed started to say there is, as the medical director of these agencies you will been responsible to say who you feel in coordination with either your training personnel or your executive people in the agencies to decide what providers would be capable of and good for this program. So that's where this should be funneled through. Paperwork is on the website. Bill has all that in order so people can apply and submit the paperwork to have the training. And like he said, our agencies have been bridged, I think Blooming Grove and New Windsor were not using it in-between as of this point. However, hopefully that will be settled now with the assistance of Mobile Life and such. But it's a thing where on September 17th we want to get as many people involved, have a trainer designated, whichever agencies want to be involved in this process and have this

higher level of care.

MR. LAMARCA: I know the medical directors will not be attending probably that training session, but one of the things I think we should comment on -- and I think Bill can back me up -- when we looked at the RSI and tried to make some decisions about its use, we found we had woeful statistics from some of the agencies using it. So for the medical directors in the room, if an agency is going to come in, just really reinforce with them we need to track this and need to have reliable numbers because we did not have that with some of the RSI. We want to break that mold and start fresh here.

DR. MURPHY: I don't think it was done that much outside of you guys to be honest with you at the receiving hospital.

MR. LAMARCA: We couldn't get data from them -- was that the problem?

DR. MURPHY: Yeah. But the process is now kind of solidified, it's really a nice neat packet with a Power Point presentation, with an educational process, a testing

process and the whole mechanism for which it should be monitored and cared for going forward. You want to talk about --

DR. STUTT: Please -- thank you. In follow-up to what Jeff presented, when he started to discuss nasal naloxone, back in December 2013 the Health Department approved nasal naloxone for BLS -- and I think you said 41 agencies have now adapted that protocol for BLS?

MR. CRUTCHER: Thirty-four.

DR. STUTT: The actual program started in 2006, not for BLS, but the Department of Health in 2006 approved in community based organizations such as physicians, PAs, nurse practitioners, health clinics, HIV clinics, needle exchange programs to provide injectable naloxone training to provide to people who overdosed on narcotics. This is a use because they recognize that many overdoses can be easily reversed in a timely fashion if somebody there had the right tools to do it.

With the advent of BLS the Health

Department, the Attorney General's Office, and the Division for Criminal Justice Services decided they want to expand it to police departments, which is a wise decision because police officers are very often the very first people to respond to the scene of a potential overdose. And the Division of Criminal Justice Services has taken a lead role in this with the AIDS Institute to providing training throughout the State. They are going throughout the State now in various regions, they will be in Ulster County in June, in Dutchess County in June as well, to provide training for police officers.

And once a police officer has been trained through a particular trainer who has been through a police training system to train individuals, those individuals can get prescriptions to their name for two doses of Narcan in a pouch, as well as a refill for seven subsequent refills. Now, not every police officer is going to have the opportunity to go to these trainings, there

will be new police officers coming in, prescriptions will expire. So there is going to be a need for police departments to have alternative prescribers. To be a prescriber for this program one has to be a member of a program that is an opioid overdose prevention program and that has to be a community based organization that provides you the right to write that prescription.

Currently REMO is a CBO, community based organization, like the AIDS clinics, like needle exchange, like a private physician office. What I would like to request is that we consider the Hudson Valley REMAC become a CBO so that any physician here who signs up to be affiliated prescription with the CBO can write prescriptions for any police organization that requests it. Now, it would not be for a police department, it would be for individuals. It's not the most efficacious way to do it because police departments that have 50, 60 members will need 120 prescriptions that will become obsolete after a period of time, 12 to

18 months. Ideally, the system will change and you could write for a police department and they may have 10 cars on the road at a time, they only need one unit per car or one kit per car.

For our organization to become a CBO, community based organization -- well we are a community based organization -- but to become an opioid prevention program what we need is to get our agreement here to have our program director, who will be Bill, we need a clinical director for that and we need to have an approved program.

The DCJS has provided a canned program with Power Point with all of the elements necessary for a police department to present it. Eventually I anticipate that DCJS will back out and police departments will provide their own programs for new recruits, but they will still need prescribers. So any physician, PA, or nurse practitioner who is involved in our CBO will have the right to write prescriptions for the police department. Craig?

Proceedings

DR. VAN ROEKENS: First of all, I would agree and support that, so I moved to support that.

But in terms of some brief discussion on that, Orange County has a task force on opioid prevention, as many know many other counties do as well. A lot of this has been foisted upon us by controlling narcotic substances and has lead to an upsurge in heroin abuse, basically across New York State. So we would like to get a lot of these police and other people out with Narcan both internasal, which has a cost, as well as injectable, which has a storage issue with it.

I agree that the way this is put about is another unfunded mandate by the State that creates ridiculous obstacles to actually implementing or saving lives. It's unfortunate because it would be just as simple to write a prescription, anyone of us, to a police department if we have met with them and seen their program, agreed it's sound and tight and there is basically a

Power Point presentation. It's not that hard, you know, we are doing it with, you know, other injectables as well too. But the hurdles are rigorous and I want it on record that they create a lot of hurdles, again for the physicians.

Again, I support that we become a CBO and allow any of the physicians here to write for that understanding that it is a valuable program.

DR. STUTT: Right now, as I said, when they do the training program police officers each get two units of nasal Narcan, atomizer and an ampujet. And instruction, they have to do hands on. The DCJS does have a supply of nasal Narcan to provide for the initial kits, but they are running severely low so it's not unlikely other people will have to prescribe for it. And I don't know how long their system will continue, how long they have funding so it may fall on the actual communities that want to do it to have their own prescribers.

MR. MURPHY: Just from an experience,

Proceedings

Rockland paramedics has been an opioid overdose prevention program for a couple of months. We had a lot of growing pains with that so we had some experience. We have -- we have trained 90 police officers in the Town of Clarkstown Police Department and they deployed their Narcan as a few weeks ago. The training is very simple. The push back from the police officers is nonexistent -- in fact, we got more years ago teaching them the AED then we did with the Narcan. It's very simplistic, the presentation is easy, the hands on is easy, the deployment is easy. We have prepackaged with instructions, two doses of Narcan, and we found the best place to put it is in the AED because the AED comes in and out each tour and it's checked each tour and they bring it in on every medical case that sounds realistic. So we have had that experience.

I have to start another police agency tomorrow, by the end of the summer I'll probably have all of police departments in the County of Rockland certified and carrying

Proceedings

Narcan. So it's a very good program and I think Dr. Stutt's idea is excellent.

DR. CORNELL: I can say from Orange County doing prehospital analysis from the trauma program, we looked at data with Mobile Life and identified quite a number of overdoses, mostly in and around Newburgh. So if you could target various police departments we suggest you target the high density and get them certified first because almost all have been happening in and --

(The speaker cannot be heard.)

DR. STUTT: The person that notifies the police department and the victim will not be prosecuted if they are found to have narcotics, providing they have no outstanding warrants, providing they are not carrying undue amounts as if for sale.

MR. LAMARCA: Have you heard any movement from the Department of Education for this to be utilized in the school system as far as school nurses? We had this discussion with two hospitals about trying to work in the school systems to get it in place at

least with their nursing -- with the nurses. But I was just wondering if you heard anything from the State level?

DR. STUTT: I don't know anything about that. Murph, do you in Rockland? It's a good point --

DR. MURPHY: They have a huge project with family members of known addicts.

DR. CORNELL: We looked at the data and put in the zip code of the school and found out a lot occur in five blocks of the school district, wondering if there is an indication of gateway drugs to other drug pedaling, it might be coincidental or real data. We are not sure --

DR. MURPHY: It's so cheap now, that's the biggest thing --

DR. CORNELL: Right. You look at opioid overdoses along with heroin compared to motor vehicle accidents, it exceeded motor vehicle accidents. It's a national project. This program is started in over 23 states now and recent presentation per the Department of Health, Thomas Freid has a nice Power Point

Proceedings

slide on-line.

DR. STUTT: Just if anybody is interested I can forward them the Power Point from the DCJS to see what is being taught.

DR. MURPHY: You want to make a motion?

DR. VAN ROEKENS: Motion is made.

DR. WILSON: I'll second it.

DR. MURPHY: All those in favor?

ALL: Aye.

DR. MURPHY: So it's unanimous. So we will start the paperwork under Eric's direction to become an opioid CBO for opioid prevention. Very good.

DR. STUTT: Bill just took another hit.

MR. HUGHES: That's all right.

DR. MURPHY: There is no SEMAC report because the meeting is June 5th.

Pad proposals. I have no proposals here to move forward.

I have a few notifications under open forum.

Lee Burns sent us a notification that it's official that St. Francis Hospital and Health Center has made the transition to

Proceedings

Mid-Hudson Regional Hospital of Westchester Medical Center. Throughout the transition period they want all communications to maintain with the agencies informing them of this transition. And, you know, everything has gone smoothly and moved forward and good luck to the new institution and such and we wish everybody well.

The Department of Health sent us two notifications regarding trauma designations. St. Luke's Hospital has been given a provisional level three trauma center designation for one year from the date of the letter, which is May 12th. And Orange Regional Medical Center has been given the provisional designation as a level three trauma center, again for one year from the date with further, you know, visitation from the American College of Trauma Surgeons and such -- or American College of Surgeons -- but just FYI for notification for everyone. And congratulations to both of those institutions.

I have a few announcements to read from

Proceedings

the Department of Health.

Under the agency Stony Point Ambulance Corps out of Stony Point, New York they have been assessed a civil penalty of $2,000.00 in violation of their New York certification, the agency code is 4324.

Please be advised that Victor Carr out of Eaton, New York has been suspended through November 30, 2014 for violations of Part 800.

Ron Dualla out of Bay Shore, New York has been suspend for one year effective February 24th and assessed a civil penalty of $2,000.00 for violation of Part 800.

Nicholas Barbou out of Dix Hills, New York has been -- his certification has been revoked as of May 2nd of this year for violations to Part 800.

And from the Department of Health also should be notified that the Bureau of EMS is sending this letter to notify us that the Milan Volunteer Fire Department no longer holds a valid EMS operating certificate. The Milan Fire Department authority has been expired since March and they will have to at

Proceedings

this point put in an entire new application, so as of this point fully suspended.

That leads us to open forum. David?

MR. VIOLANTE: Two things, one is probably it's good idea to accept the preliminary nitrous study report from this group and to continue gathering data --

DR. MURPHY: Oh, yeah --

MR. VIOLANTE: -- an ending point with the State, for one. And for two, it's probably going to get the Mobile Life study to be accepted as well.

DR. MURPHY: Do we really have to vote on QI? I don't think we have to vote on QI. It's more so a notification thing that we have to bring the information back. In terms of the collaborative protocols and the nitrous they wanted to see numbers. They wanted to see how many numbers -- was it worthwhile us putting it out tere and is it worthwhile people investing in this and that's what we are trying to prove with your studies there. In terms of the QI project, it's really more notification rather than

Proceedings

a -- but it's a thing of it comes back to this committee. We have a commitment to bring everything back this it committee and make sure we pass along the information that we get and that we support and if we are going to change something then that's a different ball of wax.

MR. VIOLANTE: Fair enough.

DR. MURPHY: Anything else under open forum?

DR. VOHRA: For stroke notifications are any EDs going from call for potential TPA candidate to CT? Is anyone doing that --

DR. BERKOWITZ: We are.

DR. VOHRA: Is EMS giving specific time last known well on the phone, or is it based upon them giving you certain symptoms?

DR. BERKOWITZ: They have to give us something positive and a time less than eight hours, but if they just call in and say I'm bringing in a stroke, you know, and that's it, click. You know, I guess if everyone is sitting around twiddling their thumbs we will probably try and do it. There is a lot of

resources you have to use to make it work because the ER doctor -- one of the things is you have to have an ER doctor see them. You don't want a patient to go into respiratory arrest on the table, somebody has to make sure the airway is okay, you have to make sure you have a nurse, tech and stretcher -- we have rapid regs like the trauma so that's one of the things that was easy you know. I think it would be trouble for everyone else, a lot of resources. But the agencies have responded fairly, I believe, to our program and said they like we are treating the stroke like emergency. There is a lot of secondary gain you get out of the process that really it's a big benefit aside from the fact that it's obviously faster.

DR. MURPHY: Have you seen an increase in TPA utilization?

DR. BERKOWITZ: No, but in the time it takes to get there --

DR. NEIFELD: Wait -- we have the same process. We take a quick look on the EMS stretcher, as long as the airway is okay and

we don't have to intervene we do a quick reg, the nurse accompanied the medic to CT, they come right back in seven minutes on average.

DR. MURPHY: I think the only thing that I always get curfuddled by is, when were they last well? I think that's sometimes so hard to get that information sometimes. Having eight hours is huge, I mean, we don't have that luxury. Even to get somebody to pin them down to when did their symptoms start, it drives me crazy sometimes.

DR. VOHRA: I guess I'm interested -- and I wish Rose was here, the stroke coordinator, if you have all the ducks in the row with last known well and there are gross contraindications notifying as a stroke alert you can eyeball them and --

DR. MURPHY: Yeah, we could pop them into CT. I don't think -- you know, if your time to CT is so much faster I think that would be great. Then you don't stick them in a room and have everybody jumping on them and do everything, you have the CT done first so you would know --

Proceedings

DR. BERKOWITZ: There a lot of other barriers. I think that the other thing is whether your stroke team is comfortable giving TPA in the absence of coagulation and platelet count presuming they're not a heavy alcoholic, but there is a lot of things that could be done to really move the process and make it faster. AHA has a program called target stroke and a lot of recommendations and they are all good recommendations.

DR. VAN ROEKENS: Again, we are all operating under this ridiculous door to 45 minute read for any stroke that is coded out on an ICD-9-10. All the hospitals are rated on data that doesn't make any difference and if it comes in, if you don't get that CT back and read it and if you are stroke center that is one of the --

(The speaker cannot be heard.)

DR. BERKOWITZ: Only if you call it as a stroke.

DR. VAN ROEKENS: If it doesn't get called a stroke I guess it's called as discharge and the State Department --

Proceedings

(Everyone is speaking at once.)

DR. MURPHY: Any other comment under open forum?

DR. SHAH: I have a question for the group with the trauma certification. Do folks know that there is no level one, no level two for New York State? It's technically area and regional, it's shifting back to ASC. We got reprimanded because we have level two on our building and the State representative was like, what are you talking about, there no such thing --

(Everyone is speaking at once.)

DR. SHAH: I'm curious if people knew about that or are we the only ones that didn't know.

DR. PAPISH: All the hospitals are using this New York State designated level one, level two, but New York State is saying there never was an actual level one --

(Everyone is speaking at once.)

DR. SHAH: -- but now the State is saying there is such thing as a level one New York State. You are either area or regional.

I just found it amazing after 25 years that all of sudden they are coming out and saying this in any case.

DR. MURPHY: Dr. Cornell, did you want to say something?

DR. CORNELL: I think the State trauma advisory committee has always designated in some way or form through the RTAC level one or level two and in the city will say level one receiving facility. I think with the change of the landscaping and the American College of Surgeons the State deciding to go on commission trauma designated centers there is a change of semantics. And having the State that had everybody is moving forward and a couple centers have been designated now by a commission on trauma, I think it was Syracuse and another one, as level ones and the rest of us are going either consultation visits and are proceeding to get designated site visits.

DR. MURPHY: Okay, anything else under open forum? Erik?

DR. LARSEN: So I was just wondering if

people got any kind of pushback, feedback about protocol changes? Because I know one of the things that a lot of the folks in Westchester have raised problems with, in fact, the only thing they really focused on is the D10 thing. Just -- so I don't know, I just want to put that out there because it takes a long time to infuse, it just means more on scene time, you know. And the one thing is for us also is we have a rapid -- shorter transport time. So anyway just throwing this out there.

DR. MURPHY: I'll revisit it and put it on the agenda because I have had medics complain to me also.

DR. LARSEN: Or anything else -- anyone else complain?

DR. BERKOWITZ: That's the big thing. I hear that nonstop. Especially four or five story walkups that otherwise the patient would have been able to walk themselves into the ambulance maybe and now because of D10 you are carrying down the patient that is 300 pounds. It's actually funny, but actually

like a real issue for the people doing the heavy lifting.

DR. MURPHY: Yeah, Andy?

MR. LAMARCA: I think some of that is born of the fact we could not get any other preparations so I mean that was the unfortunate side effect.

DR. MURPHY: Well, I'll make sure I revisit that --

DR. SILVA: There is a protocol that says to minimize errors --

(Everyone is speaking at once.)

DR. SILVA: -- that's why the option would be a nice consideration, this way you don't have to go back, there is no D50, now what do we do?

DR. MURPHY: Okay, any other comments, concerns?

Thank you everybody for your participation. This is how we get things done and move things forward, get the word out there and make sure we are all on the same page. I appreciate everybody's time in coming. I try and make them clean, neat and

Proceedings

to the punch. Thank you.

Motion to adjourn?

DR. NEIFELD: Motion.

DR. MURPHY: And a second?

DR. PAPISH: Second.

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

Yvette Arnold