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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, November 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. ERIC STUTT, Via Telephone
HVREMSCO Medical Director

DR. FRANCINE BROOKS,
Evaluation Subcommittee Chair

DR. DAVID STUHLMILLER,
Helicopter Subcommittee Chair

WILLIAM HUGHES, EMT
HVREMSCO Executive Director

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,
Director

HUDSON VALLEY HOSPITAL

DR. RON NUTOVITS,
Director

NORTHERN DUTCHESS HOSPITAL

DR. WILSON,
Director

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

NYACK HOSPITAL

DR. MARK PAPISH,
Director

PUTNAM HOSPITAL

DR. BROOKS,
Physician Representative

ST. FRANCIS HOSPITAL/MID HUDSON REGIONAL HOSPITAL OF WMC

DR. ARSHAD,
Physician Representative

ST. LUKE'S CORNWALL HOSPITAL

DR. SCOTT HILL,
Director

SHARON HOSPITAL

DR. RICHARD BENNEK,
Director

WESTCHESTER MEDICAL CENTER

DR. JON BERKOWITZ,
Physician Representative

WESTCHESTER REMAC LIAISON

DR. ERIK LARSEN,
Physician Representative

ALSO PRESENT:

DAVE VIOLANTE
MIKE MURPHY
MICHAEL WITKOWSKI
RICHARD PARRISH
ALBEE BOCKMAN
STEVE ANDERSON
TERRI BARBI
SHARON FRAZIER

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DR. MURPHY: Thank you for coming. We will bring the meeting to order. I would like to start, we have some things to vote on today.

So I would like to start by just making sure we have the full quorum and all the representation here.

Frannie, I signed you in.

DR. BROOKS: Thanks.

DR. MURPHY: David, I signed you in too. Eric is on the phone. Good morning.

DR. STUTT: Good morning.

DR. MURPHY: Bon Secours. Dr. Craig VanRoekens?

DR. VANROEKENS: Present.

DR. MURPHY: Catskill Regional Medical Center, Dr. Carlos Holden or Dr. Vorha?

DR. VORHA: Here.

DR. MURPHY: From Good Samaritan Hospital, Dr. Mao?

DR. MAO: Here.

DR. MURPHY: From Hudson Valley Hospital, Dr. Nutovits --

DR. NUTOVITS: Nutovits --

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DR. MURPHY: Nutovits -- I'm always trying to add another syllable to your name.

DR. NUTOVITS: Just call me Dr. Nut --

DR. MURPHY: That's pretty good. From Health Alliance of the Hudson Valley, Dr. Fareed or Dr. Cohen?

Northern Dutchess Hospital, Dr. Wilson or Dr. Sabia?

Dr. Papish I saw from Nyack.

Orange Regional -- Dr. Vorha.

Putnam Hospital, Dr. Butterfass or Dr. Brooks -- they have you as there too?

DR. BROOKS: Yes.

DR. MURPHY: St. Anthony's Community Hospital, Dr. Dittmeier, Dr. Roshe or Dr. Silva?

DR. VANROEKENS: VanRoekens present, director of both sites.

DR. MURPHY: Did you switch over? You are doing both now --

DR. VANROEKENS: -- trying to get into everything.

DR. MURPHY: Keeping yourself busy. And St. Francis Mid-Hudson Regional Hospital of

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Westchester, Dr. Neifeld?

DR. ARSHAD: Dr. Arshad.

DR. MURPHY: Can you spell your name for the Stenographer?

DR. ARSHAD: A-R-S-H-A-D --

(The speaker cannot be heard.)

(Everyone is speaking at once.)

DR. BROOKS: Dr. Wilson, come on. You got a seat right up here.

DR. WILSON: I'll be there in just a second.

DR. MURPHY: St. Luke's Cornwall Hospital, Dr. Scott Hill or Dr. Roberson?

DR. HILL: That's me. Dr. Roberson is not with us anymore.

DR. MURPHY: Sharon Hospital, Dr. Bennek?

DR. BENNEK: Here.

DR. MURPHY: Vassar Brothers Hospital, Dr. Ajbani or Dr. Brooks?

Westchester affiliation, Dr. Berkowitz is present.

And the liaison to REMAC at Westchester is Dr. Larsen, who is present.

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We have a quorum.

I would like everyone to review the minutes sent out by Karen and without any comment we could have additions, deletions, or corrections. We can accept the minutes. And I'll ask for a vote -- not a vote, but a first and second.

DR. MAO: Motion to accept.

DR. MURPHY: Motion to accept. Thank you, Dr. Mao. And a second?

DR. BENNEK: I'll second.

DR. MURPHY: Dr. Bennek, thank you.

So under old business, do you want to discuss the office move?

MR. HUGHES: Yes. We have confirmed our lease at a new office. It will be 33 Airport Center Drive, Suite 204. It's -- if you continue down this road to Stewart Airport you make a right, go into the airport itself and there is a street on the left called Airport Center Drive, up at the left at the top of the hill is a building there. We have a suite a little smaller than this, but it has a common conference room larger than

this. It will accommodate more people and it's a larger area. I have -- all the meetings that are scheduled we have reserved the conference room for those days, we will have the conference room and everything will be available to us. We are planning on moving somewhere in the first two weeks of December. The new landlord is giving us a month free, December, to move in. We are just getting the facilities -- building out a couple offices and putting some of the IT stuff, but we are ready to go. We will have a smaller conference room in the facility itself that will sit about 12, but the big conference room will sit about 50 people.

DR. MURPHY: Okay. And then under medical control, hospital lectures and medical control do you have --

MR. HUGHES: That was something we discussed and kind of left open last meeting. It was the hospital's need to participate into the medical control lectures. And if they weren't, if they needed help, or wanted suggestion, or anything else to come to other

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members here and we will try and give them the information they need to make sure we meet the medical control contact hours that we are requiring the paramedics to have.

DR. MURPHY: Institutions and paramedics to have.

Eric, any comments or you are okay with that?

DR. STUTT: I could not hear it very --

DR. MURPHY: It's about the medical control contact hours and the lectures from each institution.

DR. STUTT: Lectures from what, Pam?

DR. MURPHY: Each medical control hospital, each hospital should be involved in medical control contact hours for providers out there since we require them to have a certain number of medical control contact hours. We want to make sure each institution in the region is offering that capability so that providers in that localized county or region can get their total number of hours they are required.

DR. STUTT: Certainly I support that. I

guess the big question is how to encourage or enforce that.

DR. MURPHY: I guess it's not so much an enforcement -- if institutions want to remain as medical control institutions they have to follow the certain guidelines that are in the plan. I think most people do it, we just don't hear about it. And I think that's where we can improve the communication and get word out there and actually advertise some of these lectures and programs that are being put on on the website so there will be more attendance and it's more widespread of people's attendance and just get more input. I think that's more of a discussion and a process of us making sure all the information is out there and people realize what is happening. I'm sure there are some lectures on Ebola somewhere.

Okay, moving on. Sorry -- I had to get it in at one point.

Service upgrade. The Town of Wallkill Volunteer Ambulance has proceeded and completed their process for ALS upgrade. I

recused myself from the process because of affiliations I have so it was turned over to the TAG committee and Dr. Stutt and Rich Parrish, who is here today, is going to discuss the findings from the TAG and then we need to vote on the upgrade. Rich Parrish?

MR. PARRISH: The REMAC TAG for Town of Wallkill Volunteer Ambulance Corps upgrade has met several times over the last couple of months and has reviewed the ALS upgrade application in its entirety. The ALS upgrade TAG based on the information provided by Town of Wallkill Volunteer Ambulance Corps and the New York State DOH Bureau of EMS stating that TOWVAC is a BLS agency in good standing, is recommending that the Hudson Valley REMAC grant Town of Wallkill Volunteer Ambulance Corps the ALS upgrade.

The TAG would like to bring forth the following recommendations and observations:

The TAG would like to recommend to the administration of TOWVAC that they hire an experienced Hudson Valley paramedic to be the operations director. The REMAC also requests

that the name and contact information of the director of operations is forwarded to the REMSCO office.

Two, clearly state their ALS backup and TOWVAC's participation in the ALS mutual aid plan.

Three, several of the ALS agency upgrade has suffered from financial difficulties within the first five years. These difficulties usually brought upon by the inability of expansion and/or the increased cost of operations. The REMAC asks only that all ALS agencies to be aware of this and to report any reduction in services as required.

The REMAC would like greater participation of ALS medical directors and ALS agency administrators at the REMAC meeting.

Respectfully submitted by appointed TOWVAC TAG for ALS upgrade.

DR. MURPHY: Thank you, Rich. So the process was followed and everything was submitted and I believe we have some representatives here today.

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Did you want to make any comments? Do you want to address the committee? Do you have anything --

MS. BARBI: Terry Barbi, the administrator director with Town of Wallkill Ambulance. I've been with them probably nine or ten years now and we have been walking ourselves through the process now for about eight or nine months. My understanding was we were just here in case the doctors had any questions.

DR. MURPHY: Okay. So we have to bring this to a vote. And the motion for the table -- or for the floor is to allow Town of Wallkill Volunteer Ambulance Corps to be upgraded to an ALS service. The TAG committee, as you just heard, has reviewed all the application and the support of materials and it was forwarded to our committee to say everything is in order and it should be forwarded and voted on.

So I would like to put it to motion now.

All those in favor, please raise your hands.

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And those against?

Any abstain?

So it's unanimous. So that's passes unanimously. Thank you, everyone. And thank you to the TAG committee. I know it's a lot of work and certainly Town of Wallkill did a tremendous job to get this altogether. However thank you for everyone that does this work on the side to help us out. It's really appreciated.

Evaluation subcommittee?

DR. BROOKS: Nothing to report at this time.

DR. MURPHY: That's a good thing when we have to discuss in evaluation subcommittee. That's a good thing.

Helicopter committee, Dr. Stuhlmiller?

DR. STUHLMILLER: We have not had any issues so I don't have anything to report today.

DR. MURPHY: You guys are making this kind of easy.

Quality improvement report, Jeff?

MR. CRUTCHER: First off, agency audits

are complete. Any discrepancies that were noticed between the individual agencies in the office have been corrected. Work on the data base progresses. We saw a demonstration two weeks ago of the programing. They are pretty much ready to finish the back and start on the front end, which will allow individual medics to go in and check how many hours they have, when their certifications expire, and to change the basic demographics, address, phone number, that type of thing. So end of the year most likely we will see first run of it.

MR. HUGHES: And on the hospital side of it, any of you new physicians that are coming to the hospital you'll be able to check and make sure that the list is current, you can update your information and add people to it. So hopefully it will do a little bit more on-line and that will make things a little quicker and expedite things.

DR. MURPHY: Also, having the contact information updated routinely is also important for all of us.

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MR. HUGHES: Each individual will be able to update their own profile. If you change your phone number or e-mail you'll be able to do that immediately and it will reflect through the data base.

DR. MURPHY: Excellent. Under new business, now did everyone get a copy of the recommendations for the --

MR. HUGHES: Yes.

DR. MURPHY: -- from protocol. So in your packets you would have seen a notification, a letter from the office and Dr. Stutt and the protocol committee with changes and updates that are happening with the collaborative protocols. The form is here, a lot of what was done was -- and this is through many many many many meetings. A lot of what was done is to make sure all the literature and nomenclatures and verbiage was similar because we found in different protocols we were using some words that were different than others so we tried to make it all uniform. In addition the pediatric protocols were reviewed and everything put in

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there to make it weight-based and to make sure everything was standardized. And the major changes are listed on this form.

Naloxone, of course, has been added for EMTs to be able to use.

Number two, hypoglycemia has been defined as a blood glucose less than 60, which was to be consistent with what SEMAC had approved and put forth.

And nitrous oxide was added as an option under the advance provider. And what is happening there is due to the hard work of Dave Violante -- thank you, David -- we have been able to show and utilize nitrous under -- its four different agencies.

MR. VIOLANTE: Correct.

DR. MURPHY: And show the indications. And what we have been doing is providing all the information to the collaborative organization so that we can look at it from an option that more people will come on board. I know that agencies are looking at it right now for the equipment and such, but for right now we are going to continue on as

an option for the advance provider under, you know, pain medication and such. And, again, thank you, David, for all the hard work on that.

Norepinephrine has been added as the vasopressor to replace dopamine, that's a bigger one.

Haloperidol has been added as a physician option for patient restraint.

And return of spontaneous circulation protocol was changed to reflect all the stuff from American Heart and how that has changed.

And, lastly, certain agencies who provide MFI and certain agencies would like to have ketamine, so ketamine has been added under certain protocols for use for certain regions. The medical director of that region has to sign off on it, so it's not a collaborative wide protocol addition. It really is only going to be used for those agencies that want it under certain -- direction under certain medical directors so it will be very selectively. The biggest area -- Dr. Cushman's area, his area has --

will be the biggest one to use the ketamine. But you'll see it will be under facilitated extraction behavioral restraints and under adjunctive pain management. Again, it's a thing we have not adopted here in this region, but it is something for future thought and we can talk about it. It's been brought to protocol committee.

So I do have to have us vote on these five changes. Four being more of an impact, three which we had already done. The only real new ones is the addition of Haloperidol and the replacing dopamine for Norepi, which is pretty straightforward.

DR. WILSON: Other way around -- sorry.

DR. MURPHY: Yeah did I say it backwards -- yeah.

So I'll put a motion on the floor to adopt these new changes for the protocols and I'll ask for a vote.

All those in favor? It looks unanimous again. Thank you, everyone.

And thank you to Eric and the protocol committee for all their hard work. You

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guys -- again, you do all this on your own time and I really appreciate it.

MR. VIOLANTE: That starts in January?

DR. MURPHY: Oh, yes. Sorry. January 2015.

Now, because I was absent at the last meeting I can't give you an update on the BLS Naloxone program. Should that go to Eric?

MR. HUGHES: Actually, there is two parts. We talked about the citizen based Naloxone program and we asked if any physicians wanted to sign up for that. And I do have the list here, which I will pass around and you guys can sign up if you are interested in this. But this particular one I have here is an additional program that the Department of Health is going to supply Naloxone to BLS agencies. So if they apply, they come in here and they apply to us and they get their memorandum of understanding, their training and their policies and procedures and they get accepted to carry Naloxone as an adjunct then what we do is we'll be able to distribute Naloxone to them.

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Now, I haven't gotten the final contract yet so I'm not sure about the details, but for the next six months we should be able to do that. So we have about half -- half of our BLS agencies are signed up for Naloxone program. We hoped this would move the rest of them to that level. So if they use it, if they purchased this already and they need replacement, we will be able to replace it, if it's breakage, we will be able to replace even that aspect. But the concept is that we will have a supply of Naloxone that will be given to us from the Department of Health and the AIDS Institute and be able to distribute that. So that's the second part of the Naloxone program.

The first part is with the CBO, citizen based --

MR. PARRISH: The training right now, they recommend you take the video training --

MR. HUGHES: That's required, yes.

MR. PARRISH: I have a couple agencies that requested that they do a group training. And I put a program together and as a CIC

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does that meet that requirement?

MR. HUGHES: I would have to check on that because I know they wanted the certificate for each individual.

MR. PARRISH: I could -- certificates can be issued.

MR. HUGHES: Through a group program through the AIDS Institute or through the CIC?

MR. PARRISH: CIC.

MR. HUGHES: I'll have to check and get back to you guys on that.

DR. MURPHY: That's pretty much it on that.

MR. HUGHES: Yes.

DR. MURPHY: Probably the greatest thing we have all been rushing around and working on, I can't imagine there is not a person at this table that hasn't been involved in some aspect or another, is this whole process of our Ebola advisory and for the information and such coming down from the Department of Health and from the governor and there has been meetings, upon meetings, upon meetings,

upon meetings. The new Commissioner of Health, Dr. Zucker, asked us all to participate in a telephone conference call just so that we could all be on the same phone and listen to the same information being given out and it was opened to a discussion for people to bring forward any communications or concerns they had. I have here both the recommendations and I have also kind of a synopsis of that phone call. I know quite a few of you -- you were on the phone call, right?

DR. BERKOWITZ: I've been on so many phone calls.

DR. MURPHY: With Zucker?

DR. BERKOWITZ: Yeah, I remember being on that one.

DR. MURPHY: Yeah. Like I said, there is a plethora of information abounding. It pretty much fell in line with what we put forward as our advisory and everybody should have a copy of the advisory in your packets.

And long story short we tried to keep in line with what is coming forward and being

put forth. Again, it seems like things change as much as the wind does.

However, the main parts we setup were to make sure our dispatch centers or the public safety answering points, whatever that ends up being, whether it be a caller into a 9-1-1 center, that it is standardized. And what we tried to do in this area is promote an advisory to help people so that they know kind of the purpose and general recommendations and put forward basic steps for each level of care.

That being said, again, we had another committee that got together with this -- and Mr. Benenati is not here today, we can't give him praise and singing --

MR. VIOLANTE: Give him as much praise as you would like.

DR. MURPHY: -- for tying this up and putting it together. In a nutshell, it kind of fits in line with what the collaborative committee brought up and also with what we talked about on Dr. Zucker's phone call.

And, again, we tried to put in here to

limit the contact for BLS agencies, just to make really the contact with anyone as little as possible, tried to get to determine really with that first person on the phone, that answering point, that is it truly a possible Ebola exposure or not, and to follow forward with a process to try and minimize contact.

The biggest thing that has come forward with all of these communications and with all of this interaction with the Department of Health and with the governor is that -- is a concern of does every single agency out there have the capabilities of having the personal protective equipment that is required and the cost and the preparedness and the training that is, you know, requested by the Department of Health to be done on a regular basis and without really any assistance to these agencies. So we put forth recommendations of trying to get either equipment donated to these agencies that are out there in the outskirts that do not have this material and guidance for them on how to do the education and such and could we make

it so that we have localized regional areas of -- for people to get the training so these small agencies don't have to put out the money or have to scramble to meet the requirements.

And, again, our first and foremost thing here is for everyone's safety. And that's why we felt it was so important that the Commissioner of Health really look at and realize what the resource utilization will be and how we tried to minimize the risk and exposure and yet not bankrupt some of these places that need to abide by all these recommendations.

We definitely put forward as a committee from the collaborative protocols, we put forward basic recommendations to the Department of Health and we put them in writing. One, no BLS first responder should have patient contact, we should try and keep it to ALS level, no intubation because of close contact and risk to personnel. No nebulized treatments with substitution of a metered dose inhaler, if indeed required, and

no CPR of futility or hazardous nature to the personnel involved and minimization of any kind of IV sticks or parenteral medications. There is no advent of -- if there is an issue of the person it can be injected and utilization of injectable Haldol or IM medications, midazolam or some of the ones that fall under our protocols. But with the REMO -- sorry -- REMSCO advisory here everyone should read it as an advisory. It's really one of the interim things to try and get us over the hump of kind of the onslaught of all this information and all coming in and to make sure we are all on the same page.

I know all of you have probably been on all these meetings and such, but I wanted to open the forum to anyone needing to ask anything, needing any resources and make sure we are all on the same page.

Any questions, comments or concerns? Is everybody Ebola prepared?

DR. LARSEN: Does the Hudson Valley have a mechanism to transport a patient who has been determined -- brought into a center

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already? So they are at one of our hospitals, you know, probably one of our emergency departments and now they are going to be sent somewhere -- to one of the fabulous Ebola treatment centers -- do we have a designated transportation system for that?

DR. MURPHY: What we put forward was we were thinking from -- not from the Hudson Valley Region, but from the whole collaborative protocol we thought the best way for these people to be transported would be in a police or other agency vehicle other than an ambulance, unless they are clinically not capable. Just because -- this is what we put forward, just because it would be easier to decontaminate and take off-line that kind of transport vehicle than an ambulance. So that was what was put forward. We have not heard back yet.

DR. PAPISH: Sounds like wishful thinking.

(Everyone is speaking at once.)

DR. MURPHY: Yeah. And I think -- well,

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my biggest thing that I said to Dr. Zucker was, why transport anybody? I mean unless somebody is really really sick and we really know of the exposure that -- I think 99.9 percent of everything we are going to be queried about, not so much New York City, but up here, is just people mal informed and not understanding what happened. I did go to a bowling alley last Saturday night, does that mean I have Ebola? It's these kind of things. So that's what I was trying to make a recommendation of, is you have these people in Texas quarantined in their homes, which is fine because a lot of them weren't sick. So a thing of can't we keep people where they are rather than transport? I think is a much better issue. However, if somebody is really sick, you are correct.

What -- Dutchess County did a very nice process and worked on a program. And what they put forward was their county is going to work on a strike team that if this does occur a strike team responds. And it's a designated set of individuals that have the

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proper equipment, proper training and will respond to a real threat and --

DR. BROOKS: To the point house or location. Basically when -- if I am wrong, Dave, let me know -- but if a patient calls or such a call -- 9-1-1 center gets a call and the Health Department gets involved right away and the patient doesn't get moved until there is a plan of action before they leave their home or the environment they are in and they will tell us what to do, with that each hospital has pretty much gotten it together and they have rooms, you know. I know Hudson Valley has, we have, and Northern Dutchess has, so the three hospitals actually have a protocol in place if they are brought to the hospital in the ambulance and that's what they are told to do. They wait out in the ambulance until the ER is ready to accept the patients and each of the hospitals has one or two rooms specifically setup and a plan of care for those patients after the ER. And I believe not to stay in ER for more than an hour and they get brought to ICU, CCU in

designated rooms. So the plan is to keep the patients in the area.

There is an issue how do you transport them down to Bellevue, Mount Sinai, one of the hospitals who does it. Do you contaminate another rig after one rig is already out of service. You are talking about that rig being out of service for eight hours by the time it's cleaned and you have a transport team from up here then down there, or do you wait for the transport team down there? So I think the county and hospitals decided, let's go ahead and treat these patients, we should have the stuff to treat them.

DR. BENNEK: We are just looking at requirements and I found we would run out of equipment in a very very short time. You are talking about at least two or three nurses in addition to the doc, only in zoot suits at most four hours. How many suits do you need in a 24 hour period? How many suits do you need to keep?

DR. BROOKS: There is no plan of

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transport though --

DR. BENNEK: That's what I'm saying, that sort of has to be imperative if we are going to deal with this. There has to be a central place to bring the patient that has the equipment and can sustain the effort. We have a plan for taking care of the patient for 24 or 48 hours, but after that we will run out of personnel, number one --

DR. BROOKS: But --

DR. LARSEN: Dr. Stutt, did you want to say something?

DR. STUTT: I did. First of all, in the advisory there are referrals to getting information from the Department of Health, in giving some responsibility to the Department of Health to decide about transport issues. EMS is supposed to be doing -- and I think it would apply to the hospital situation as well -- have the Department of Health get more involved with directives as to where these patients should go and how they should go. I don't think it should be left to the last minute for everybody to figure on their

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own how to do it. And where is the Department of Health on that issue --

(Everyone is speaking at once.)

DR. STUTT: It was very interesting to hear from Dr. Reva about Dutchess County's approach about the idea of strike teams. I know that has been discussed and I don't know if that has been followed through on State Department of Health --

DR. MURPHY: When we talked to him basically those things were brought up and what we did is put it in writing. I can read it to you.

For medical equipment and transportation, to minimize risk of contamination vehicles other that ambulances must be best suited to transport -- may be best suited to transport high risk patients. Most of these patients are not in extremis and the focus of safety and the best interests of all involved is the minimization of disease spread. Wheelchair vans or law enforcement personnel transporting vans maybe better suited for transport rather than

decontamination and loss of all these ambulances. Patient care equipment carried on a nonambulance vehicle used an alternative transportation would need to be minimized so that we do not incur waste of disposal equipment from cross-contamination. This would require though an exemption from Part 800 inspections for transportation of high risk patients during this crisis.

So we definitely put forward to him he would have to look at Article 30 and all these disposition and transportation issues. There is no word that I know of -- and someone at the table can correct me if I am wrong -- as an answer to all that we put forward to him, that was October 23rd. And there was a few other things, but that was the main gist of it and I don't believe we heard anything back.

Dr. Hill?

DR. HILL: So it was my understanding that once you got a confirmed Ebola case Feds will takeover transport to a center of their choosing -- which would probably be Bellevue.

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We bear responsibility taking care of things until it's a confirmed case. And once it's confirmed case it's federal, was my understanding. So, you know, we might have 10 hours of care or something like that, but it shouldn't be 24 hours.

DR. NUTOVITS: So I think the idea is that -- I think it's still local DOH will decide where it would go, but in conjunction with the CDC. They are trying to get federal mandates within the states where they don't have jurisdiction. Initially the thought was it would be a few hours, if it took 12 hours for the kid in Bellevue to be confirmed --

(The speaker cannot be heard.)

(Everyone is speaking at once.)

DR. MURPHY: Dr. Berkowitz?

DR. BERKOWITZ: One of the issues that I foresee with this is just the specimen transport. There is really only one lab and not everyone has identified the specimen transport. And the county DOH -- if FED makes contact with county DOH the length of time the patient will spend in any of our

hospitals that is not designated will be really proportional to the amount of getting the specimen down, you know, which is faster and faster as they do more of them. But still will probably be for us in this region it might be just the mechanism to get that specimen transported will be one of the biggest barriers. So I don't have a solution for it, but I foresee that being a practical issue.

DR. PAPISH: At one of the last meetings Montefiore is going to be one of the local receiving centers. They had said, although not fully operational, once they are they will would be willing to take patients just PUI, without doing any phlebotomy, if they meet the definition of PUI they would take them off our hands.

DR. VANROEKENS: I would basically -- speaking for Montefiore -- no facility will accept any patient at the present time unless they are indeed confirmed positive test. Sure, we'd be interested in hearing at Montefiore you have a concern and that

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Montefiore has a protocol, which includes the ID person and local Health Department, but think have the capacity, Bellevue has four beds, all these facilities basically have single digit capability in terms of capacity.

So I think the point is patients will need to be kept either in EDs or if you choose to put them in ICU you want to think about that. I urge you to think about how sick that patient is. Most people recommend keeping the patient in the ED if they come, present, either as walk-in, or they happened to be transported because you want to minimize the contact. Again, many of you might have listened to the CDC call. I think that's a useful call, where you heard about the eight patients treated previous to Spencer. The way that they were treated speaks to the intensity and the time a positive case would take. Most of our cases are going to be, geez, well, I was worried. I took the subway. I was bowling. You know, I was in an airport, somebody was coughing. I think they were from Liberia. At the

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present time nine cases confirmed in the states, one death. You know, a lot of false positives in the city, that's where the action is in terms of the number of cases and the majority of those are malaria.

DR. PAPISH: How many actual PUI have we had in the region?

DR. VANROEKENS: I don't know about this region. I can speak for -- we had two concerns where calls went out to the Health Department and there is a lot of hysteria. I'm talking about St. Anthony's and Bon Secours. The one at Bon Secours, the call didn't go to the Health Department because we stopped it. But St. Anthony's, they did call the Health Department and it was nothing. And many of you probably have that same experience within your own ED. Geez, I'm worried about this and the call gets to the director, or nurse management, or leadership or ID -- in some of these the Health Department is called.

I don't know the total of calls in Orange County or any of the counties of the

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Hudson Valley, in the city many of you might be getting the mental health, you know, the city report. That's a very useful report because of it basically states how many cases, what's the percent of those cases in the people that they are following. That's useful information because they are following a lot of people, but most of the cases that were really concerning were malaria.

DR. BERKOWITZ: And I think, if I remember right, just from the SITREP, you know, I think they were talking about I think 35 PUIs was about the number I saw, none of which had ruled in. Those were people that likely had a --

(The speaker cannot be understood.)

DR. BERKOWITZ: -- with travel to one of the countries without actual risk exposure. And that is the numbers we are working with.

One of my concerns is that actually someone is going to come in sick from Liberia with sepsis, no exposure, and people are going to run from their room and the patient will die from malaria or whatever --

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DR. VANROEKENS: As one of the reports ectopic pregnancy was delayed a little because people had concerns about that.

DR. MURPHY: Well, and flu season is like a short breath away. So we are going to get inundated with febrile patients.

DR. BENNEK: Actually, I think that is a big issue which is, you know, you have flu season, a lot of other people, there is a big potential for people to get sicker and/or die because of delays in care. We really should address that to make sure any decision making is really abbreviated as much possible, a diagnosis should be done in 10 or 15 minutes whether to transport a patient and a lot of communication what the risk is actually. And most of the patients we are going to see are going to be flu and the occasional malaria patient that could be worse, but the thing you -- you don't want people to meet their demise because of delays in care. I think that is worse than any risk Ebola may present.

DR. MURPHY: Yeah. I think that the

variability of each region, each county wide and County Department of Health, there is a lot of variability, so you could have one county doing something and the other county definitely on a different page. I think that's a huge thing that we also brought up to Dr. Zucker was, you need to look at the county resource and make sure we are all on the same page and doing the same thing. That's why we went back to that process of -- and for lack of a better term -- that came out of Dutchess, is a strike team. Could there be a strike team for every single region so that unification and standardization is done through one dispatch, one medical director, even designate a medical director as the go to person to make the decisions so the decisions that are made are consistent and we stay on the same page and ignore some of the other things that can occur and can move towards treating these people that have other things. That was some of the other issues we brought forth to him.

Again, I don't have an answer for you,

but that is what the concerns were.

DR. LARSEN: One thing we have in Westchester is that Westchester EMS has agreed to be a transport agent for folks from a hospital to a designated Ebola treatment center so that they have an ambulance that they can lineup and protect. They get their folks, you know, geared up and they can promise us about a three hour response time if we notify them so if we have to have a patient transported and they are willing to extend that service at least throughout Westchester to transport a confirmed patient. Or, you know, depending how it goes down, if it's a highly suspicious patient that is going get transferred beforehand -- which I doubt -- seems that with a more rapid turnaround of the test, the Ebola test, that, you know, they would only be taking confirmed patients.

DR. BERKOWITZ: If the DOH was monitoring someone and, let's say, a nurse who came back and was in Westchester County somewhere and they said -- called DOH and

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said I have a --

(The speaker cannot be understood.)

DR. BERKOWITZ: -- go pick them up too or is this strictly interfacility?

DR. LARSEN: Right now it's for interfacility. We need to talk about whether this would be a 9-1-1 response, but as of right now it's interfacility.

DR. MURPHY: Okay. Any comment or concerns on the quarantines? No comments. No concerns.

DR. BENNEK: I wonder how far it will extend. If you have one taking -- the nursing staff in your hospital taking care of one potential Ebola patient what do you do with those people? If they are having to be quarantined for 21 days your staff is going to be eaten up, or it will be exclusively taking care of Ebola patients and nobody else. I work at a small hospital, we run out of people quickly. We have to be able to take care of the rest of the patients or we would have to shut our doors. I don't know if you take it -- if you are monitoring a --

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the staff member, that's one thing, but if you are actually quarantining them that becomes a different story.

DR. LARSEN: Don't worry the publicity will shut your doors anyway.

(Everyone is speaking at once.)

DR. MURPHY: Well, hopefully most quarantines will be done -- this is the question I asked Dr. Zucker, if somebody is not sick why do we transport them? Why don't they stay where they are? And they would -- the Department of Health can legally enforce and put armed guards outside of someone's home if they are put under quarantine at their home and they are under house arrest they can designate --

DR. VANROEKENS: Unless you have a good lawyers from the ACLS.

DR. MURPHY: Okay, thank you, everyone. Any other comments or concerns?

Under SEMAC report do you have anything to add in terms of it pretty much was the collaborative stuff, the meetings coming up, and I think that was --

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MR. HUGHES: Well, the EMT --

DR. MURPHY: Oh, yeah. One of the programs that actually had started before and had been under consideration was for the utilization of EMTs to use CPAP. And as you know, many things have been -- not many things, but new things have been brought forward to use at the EMT level and what SEMAC was promoting and discussing was protocols for just that, to allow under strict protocols, strict advisory of when and when not to use the CPAP for utilization of, you know, noninvasive ventilatory efforts at EMT level. So that is still in the works of being -- but it's on the table for discussion and for utilization and moving forward.

MR. HUGHES: It's actually been approved by the SEMAC and the SEMSCO and has moved to the commissioner and the commissioner needs to sign off --

DR. MURPHY: Well, it's on his desk, put it that way, the protocol, the criteria and what it would be for the exact patient to utilize it on. SEMAC approved it the meeting

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before, but I think it went to SEMSCO this time --

MR. HUGHES: Right.

DR. MURPHY: And, again, it was forwarded to the Commissioner of Health --

MR. PARRISH: What took place at SEMAC was at the previous meeting I brought up the issue we were having with PCRs and Dr. Dailey from Albany Med brought it to SEMAC. And I got to support him and every doctor at that table, just like at this table, supported that, yes, this is a system wide problem. And some other doctor that I have not seen before at SEMAC stated that he got a CMS citation for not having the PCR in the medical record. And what they did -- Dr. Dailey made the motion that it is the responsibility of the vendor and/or the agency -- not the hospital -- to get the PCR. And that went to SEMSCO and SEMSCO passed that motion. When I sent an e-mail up to them asking them to send out a clarification about that, that has not happened yet. I think that this group here needs to support

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that position.

DR. MURPHY: And what Rich is meaning by that is -- I don't know because I wasn't at that meeting so I don't know who the doctor you are talking about who got the citation. However, what it refers to is that you in real time have a PCR in your hand when you are treating the patient in the ER and that documentation, that piece of whatever it is, whether it be electronic medical record that they are faxing into, or giving you a copy at that time, be available. And what the motion Rich is talking about and to -- and we can make a motion for this table and for this committee is to back the support of the institution that they can't be held libel nor the doctor who is receiving the patient because they don't have any control over that PCR generation and PCR completion.

And, you know, I know that it becomes an issue when you talk about medical litigation and cases, case law and cases I've reviewed have clearly had in their -- you know, did the provider have the prehospital

documentation when they took care of that patient? So we can make a motion here to be also on the same page as SEMAC to say that we would be in support of making sure that the -- these contracted -- what did you call them?

MR. PARRISH: The vendors.

DR. MURPHY: Vendors -- sorry.

MR. PARRISH: And the agency, the one agency I'm dealing with, the vendor does not have -- or does have but for extra charge the capability to e-mail, fax, and the agency has elected to not to pay that extra charge for that. So they go back -- and to this date they have yet to submit PCRs. They want us to go onto a desktop, have the charge nurse signed onto this desktop and download the PCR. And that's the only agency that has asked us to do that, everybody else, Mobile Life, Diaz, everybody else gets it to us. Some don't get it to us when they leave and we have come up with a five by seven pink card that they fill out and they give it to us. And I sent it to Dr. Stutt because he

asked for a copy of it at our last meeting and that's what we are doing. If you can't leave your PCR at least leave the patient demographics and what you did for that patient, especially if you gave them drugs, so the physician has something and then they are supposed to get us the PCR, like Diaz gets it to us within an hour.

DR. MURPHY: So I would like to make a motion from this committee that we support this initiative to try to make it so that each agency will in real time get us copies of or provide documentation of that prehospital care and interaction. I would like to make a motion for the table.

DR. WILSON: Second.

DR. MURPHY: All those in favor?

It's unanimous again.

Thank you, Rich.

Anyone -- anything else anyone wants to add from SEMSCO because I don't go to that meeting. Anything else?

Okay, under PAD proposals, Epi, Albuterol, glucometer and Narcan we have no

new proposals to put forward at this time.

Under new business, I forgot -- Dave, could you speak to the part about changes to Part 800?

MR. VIOLANTE: The State sort of semi-ubiquitously sent out at the end of September some amendments to Part 800 for a public comment period under Public Health Law Section 3002. To clarify terminology, eliminate vagueness, address legal statutes and incorporate modern professional, ethical and moral standards. The idea is that the bill relates to the certification, recertification, CME, required conduct, suspension and revocation of certification. So those changes may or may not affect this group in some way, shape or form.

I believe Bill has a copy of what those changes are and can send them out to anybody here if you so request.

DR. MURPHY: The Part 800 definitely affects the SEMSCO -- sorry, the REMSCOs more. But I just wanted Dave to bring it up so we are aware and that, you know, any kind

of changes that are occurring and things that will impact us down the road we should always be aware of. And I think that level of communication is important.

New business under open forum. Anybody have anything they want to add this morning?

MS. FRAZIER: Sharon Frazier, MidHudson Regional Hospital. I wanted to address PCRs left at our ER that are not completed like times or certain things and we are encouraging them to leave something -- like Rich has that demographic sheet. What I would like to ask is if it's encouraged that the agency provide a completed PCR because the providers will complete that before they submit it to their agency, but we are not getting that, we are getting the incomplete one.

DR. MURPHY: I think there has to be some communication between the agencies and some designation or designated person at the hospital -- whoever it be -- the liaison or whether it goes through the director's office, just so that each agency has a

modality of getting the information to the hospital, whether it be by fax, electronic, or -- you know, I think that chain of information, that communication is vital and time sensitive. I think it shouldn't show up two days later. I think it has to be relatively within the time frame of us treating the patients. Thank you, Sharon.

Any other comments or concerns?

Also in your packets we put out the dates for the 2015 meetings. Again, it should be at the new office like Bill described. However, the dates are there so we can have everybody aware ahead of time and that -- again, thank you for your participation. I know everybody is very very busy and we are constantly reading about Ebola now, but thank you for coming. This was an important meeting because we had to vote on so many things.

Motion to adjourn?

DR. BENNEK: Motion.

DR. MURPHY: Second.

DR. HILL: Second.

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DR. MURPHY: Okay, thank you, everyone.

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


Yvette Arnold