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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, 33 Airport Center Drive, New Windsor, New York, on Monday, January 5, 2015, at 9:30 a.m.

Yvette Arnold,

Court Reporter

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

DR. PAMELA MURPHY,
Committee Chair

DR. ERIC STUTT,
HVREMSCO Medical Director

DR. FRANCINE BROOKS,
Evaluation Subcommittee Chair

DR. DAVID STUHLMILLER, Via Telephone
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. ANUJ VOHRA,
Physician Representative

GOOD SAMARITAN HOSPITAL

DR. DENNIS MAO,
Director

HEALTH ALLIANCE OF THE HUDSON VALLEY

DR. FAREED N. FAREED,
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. BUTTERFASS,
Physician Representative

ST. FRANCIS HOSPITAL/MID HUDSON REGIONAL HOSPITAL OF WMC

DR. ARSHAD,
Physician Representative

WESTCHESTER MEDICAL CENTER

DR. JON BERKOWITZ,
Physician Representative

WESTCHESTER REMAC LIAISON

DR. ERIK LARSEN,
Physician Representative

ALSO PRESENT:

DAVE VIOLANTE
ANDY LA MARCA
MIKE BENENATI

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DR. MURPHY: Good morning. Let's bring it to order. I'm passing around the attendance sheet. It's really just a tick box, I ticked most of you that are here. Please, everyone in the back and the guests, sign in, there is another sheet going around. Make sure we have everybody down and get credit for it.

Thank you for coming this morning. Thank you for finding the new building. It's not that we like to play tiddlywinks with you and keep you moving around the county, but this is much nicer space and the other place -- we had outgrown it really and this works out much better, being juxtaposed to the airport I think everybody can find it.

I would like to bring up the minutes from the November meeting. If anyone has any corrections, deletions, additions, anything they want to amend, please let me know. We don't have a full quorum yet so we can't vote on them. I'll come back to that, but does anybody have comments, anything they need to change or amend?

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Okay, moving on. Under old business we have the 2015 collaborative protocols roll out. I'm pretty sure each one of you received an attachment from Bill here at the office the latest revision and with it is the color coded same kind of formatted protocol so it should have been attached to everyone so you can look at them.

We discussed last time the main changes, but one of the things I forgot to mention is Dr. Dailey did a really nice presentation of the roll out and the new changes and actually has a video you can watch and it's attached right now to our Facebook page. We are going to put it up onto the regional office website soon, but it's a great thing you can give to your providers, give to your staff in the ER so they can watch and read it and he talks a little bit about why the changes were made. Dr. Dailey is very central in terms of taking in all the information where it comes from each one of the regions and he tries to put it altogether and say this why we are making these decisions. And it's always made in

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such a way that all of us vote on it -- oh, I have to interrupt for one second, this is Dr. Stuhlmiller.

Dr. Stuhlmiller?

DR. STUHLMILLER: Yes.

DR. MURPHY: Thanks for calling in -- this is Pam. So I'm going to adjust the agenda right now. He had to call in, but I want him to be here to discuss with us the new helicopter protocols. So I'm going to turn it over to you, Dave. I just had started the meeting, just a couple things, but we are going to alter the agenda just so we can have you on here now and have you go through the helicopter committee report and the new protocols. Hold on.

DR. STUHLMILLER: Thank you, Dr. Murphy.

DR. MURPHY: Go ahead.

DR. STUHLMILLER: Thank you, everyone. I'm sorry I cannot be there in person today.

However, as was requested by members of the REMAC last year to look at and revise the air medical operations guidelines for the region and so our committee worked at our

last meeting and in-between electronically to revise the documents that we shared with the members of the REMAC last month. I hope you had an opportunity to review it.

Briefly there are a couple of changes. First, we added a statement saying that the clinical capabilities of the medical personnel and the equipment and medications on the aircraft might benefit the patient is another reason to utilize medical transport. We changed the auto launch word to airborne standby, which is a more appropriate term and descriptor for when our request to standby is greater than 25 miles to the closest available helicopter asset, that helicopter will launch and standby heading toward that scene. Thirdly, we added specifications for all of the air frames that are in use, which describe where the lowest points of the router disk is, how to approach the aircraft, whether a tail guard is needed or not, et cetera. I hope we updated the hospitals in our region correctly regarding pediatrics, neonatal, strobe, STEMI, whether the Health

Net is present or not, et cetera.

And so we worked hard as a committee, I'm very pleased with the contribution and thank everyone for the contributions on the committee and ask for any comments or hopefully we can accept the document.

DR. MURPHY: Any comment or concerns in the room? I'm not seeing any people raising their hands or anything, David.

The only problem will be -- now we have Dr. Papish -- so we should have a quorum now because now it's seven.

Yes, so we can vote on them, David. I thought we didn't have enough --

DR. STUTT: He doesn't count.

DR. MURPHY: Correct -- but he counts in my eyes. We have enough to vote so why don't you make a motion for the agenda and then we can vote.

DR. STUHLMILLER: Yes, ma'am. I move that the REMAC approve that updated air medical operations guideline as presented.

DR. MURPHY: Do I have a second for that motion?

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DR. STUTT: Second.

DR. MURPHY: And all those in favor? One, two, three, four, five, six, seven, eight, nine. So it goes unanimously. Thank you, David.

DR. STUHLMILLER: Thank you. Happy New Year everyone.

DR. MURPHY: Happy New Year to you, bye.

Sorry about that. I forgot to tell you I was going to interrupt the meeting whenever he called in.

So going back, so there is a good presentation for any of your staff, anyone that is interested actually, and to know why certain changes were made and kind of the historic facts behind how they came down. And, again, it's on our Facebook page. We will have it up -- Bill will get it up onto our website and you can access it there and just watch. It takes about --

MR. HUGHES: 45 minutes.

DR. MURPHY: -- 45 minutes. And it's a nice succinct little presentation though. And we expect that everyone gets the new

copies, the new small changes, to each one of their companies and emergency departments and make sure everyone gets up-to-date with the 2015 changes. Albeit small, but I think they are definitely still positive things.

That brings into key at the end of this month all the doctors' credentialing and process your cards are going to go out of date. We just need to have each institution update the roster, get it back to Karen and she will dispense new cards to everyone. The only person that would have to take the exam would be anybody new on the staff. If everybody is the same sign them over, update the roster so we know who is there and who is not and bring it forward. If there is a new person submit the name and such and we will have them take the exam. Again, it's open book. So we can get them a card and have everybody credentialed appropriately. We sent the information out to the hospitals, Karen has only heard back from two hospitals so please remind your departments to get back the information.

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BLS and Naloxone update, I'll let you just say two words.

MR. HUGHES: The BLS and Naloxone program has been accepted. We have filed a contract and we are just waiting for the Naloxone to come into the office and start distribution of it. For an agency to get a distribution they must sign into the Naloxone program, they must have the memorandum of understanding and the training process in place and then we can distribute to them. There will be no cost to the agency, it's being paid for by New York State Department of Health.

DR. STUTT: That's going to provide for BLS agencies, ALS agencies as well or just for BLS and police?

MR. HUGHES: BLS agencies, BLS FR and police.

DR. MURPHY: Old business. You have also down Ebola here. I don't think there is much more to talk about on Ebola.

Did you want to bring anything else up?

MR. HUGHES: No, just that it hasn't

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gone away.

DR. MURPHY: Still in every one of my notes no, the patient hasn't traveled in the last 72 hours.

MR. VIOLANTE: Just a clarification for the collaborative protocols, that's just the roll out and while this body accepted them they have to be approved by the State --

DR. MURPHY: Yeah. Unfortunately the next State meeting is the 13th. We didn't have one between our last meeting in November so it will come on the agenda on the 13th, January 13th.

MR. VIOLANTE: The update is good, we can't implement them until that date --

DR. MURPHY: Correct.

Service upgrade, we have none at this time.

Evaluation subcommittee report?

DR. BROOKS: Nothing.

DR. MURPHY: It's interesting, we haven't had an evaluation committee in a while and that could be a good thing, that could be people are handling it and taking

care of their problems, or it's a bad thing we are missing things.

DR. BROOKS: There have been issues taken care of before coming here --

DR. MURPHY: Yeah, and also in an appropriate forum and appropriate setting, not everything has to come to the committee actually.

Under helicopter, the guidelines we just did with Dr. Stuhlmiller. Any questions or concerns? Everybody is okay with all that? That was sent out, I believe, last month everyone should have had it and if you need another copy I'll send you another copy, let me know.

Quality improvement report, Jeff?

MR. CRUTCHER: Nothing outstanding as far as issues.

We have in the last year put 45 agencies on-line with BLS Narcan. We continue to test providers as they come through for the MAC exams with varying degrees of success. First time candidates usually aren't fairing too well, usually second time through they do

okay.

DR. MURPHY: Meaning first time people that are taking the protocol exam --

MR. CRUTCHER: For the first time, yeah.

DR. MURPHY: Is it because they are not exposed to it, or they are not coming in prepared with the information in there?

MR. CRUTCHER: They are not coming in prepared.

DR. MURPHY: That kind of rolls into one of the discussions we kind of had offline, Dr. Johnson from SEMAC sent out an inquiry to everybody on SEMAC how we wanted to handle the CPAP for BLS initiative. And, basically, what has been decided -- I'm sure at this point he is going to announce at the SEMAC -- is each REMAC will be responsible for how we want to handle CPAP at the BLS level. We will make the decision of how people come on board, how to do it and how to facilitate the process. And, of course, we will do it in possibly the same format we did the Narcan, the same format we did albuterol and epinephrine, that will have to go through and

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be setup by the protocol committee under Eric. But as it stands right now, the way we think it will come down from SEMAC is each individual REMAC will be responsible for orchestrating the roll out and facilitating the process for the people to use the modality.

Under new business, I talked about the credentialing process for the EMDs, the CPAP. I don't think I had anything else.

Anybody have anything for new business?

Mike, you are being awful quiet.

MR. BENENATI: Just with the new protocol we need to know when and how to roll out. What is the process? How we are going to do it? What is the training program? And get-together as protocol committee to discuss that.

DR. MURPHY: I think the one thing we are definitely going to make as we talked about -- and correct me if I'm wrong -- we will make each agency responsible for their individual roll outs. But what I thought was take a look at Dailey's video because I think

it's an easy way to do a lot less legwork and people can use it to their advantage. He is a good speaker and talks about the new additions that we put in there and why we changed things and some of the information behind it, which I thought was good. So that will be the way it is done, in terms of we didn't put really a date out there in terms of people having to come back. It's more so just such a few things, it's really to keep people going and updating on it. In per se of a roll out I think each individual agency just has to make sure guys are up to snuff -- guys and gals.

MR. BENENATI: Like David said, so the agencies are clear, we should not be implementing until we get State approval to do that --

MR. HUGHES: I'm not totally sure that that is correct. I'm trying to remember back and I have to look at minutes from the State MAC, but I believe that once they voted on the protocol, and the protocol was voted in for the REMO region, and I believe they said

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we just had to send a letter saying we were going to -- that we adopted their protocol -- the accepted protocol.

DR. MURPHY: Well, we are part of the collaborative process.

MR. HUGHES: I understand, but each region needs to get their own approved. Once it's been approved at the State level I believe all we have to do is send them a letter stating we will participate in that already approved protocol. I don't think we have to get ours approval.

MR. LA MARCA: I guess I'm not sure, if we are in the collaborative if anyone in the region in the collaborative gets approval of the protocol, if the others can just marry into it just by a letter that's --

DR. MURPHY: This is the way I thought it was because the way the collaborative protocols is written each one of us are outlined in that collaborative body, so each one of the regions are there and we are under that region. But I don't remember -- my thing is I don't remember them approving it

at the November meeting because I went to standard. So I think it's going to have to be this meeting, to be honest with you. I don't think it went through. They put them forth to be looked at, but we didn't vote on them that meeting.

MR. LA MARCA: I thought we had information, but not a vote --

DR. MURPHY: Correct, that's what I thought. Because we are part of the collaborative we will be always accepted as one huge entity, it's not like each individual person has to do it. We are as part of that entity --

MR. LA MARCA: For protocol issues I'm sure, but you preserve your own identity --

DR. MURPHY: Yes, you can have changes and differences, like we have nitrous. There will be some differences region wise and region specific, but it always is going to say on there people can have it if they have the resource and whatever they need. Like ketamine, not everybody will carry ketamine, but some areas will be very heavily into

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every agency carrying it.

MR. LA MARCA: Logistically the way it's setup with the collaborative each of the regions have representation to a committee so when it actually comes to protocol issues it's not being brought by a region, it's being brought by the collaborative en mass, correct?

DR. MURPHY: Correct, as a collaborative association together. And I'll clarify if there has to be a letter of understanding or letter of agreement. I'll clarify --

MR. HUGHES: And we first need to see if it was voted on.

DR. STUTT: Whether we need to for not, if we vote on it it's free to send the letter once we find out they request a letter from us we can say we approved it --

DR. MURPHY: We can absolutely -- do you want to put a motion on the table to approve the --

DR. STUTT: I move that we approve the 2015 collaborative roll outs.

DR. MURPHY: With the new changes and

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new --

DR. STUTT: With the new changes certainly.

DR. MURPHY: I'll second that.

All those in favor?

MR. LA MARCA: Just a question before you approve it, with that do you want to establish a date -- presuming we will get it January 13th --

DR. MURPHY: Yes, January 13th is the --

MR. LA MARCA: -- of course. What would be the implementation date if you approve it now? We are midway through the month. When it gets approved at SEMAC or SEMSCO I don't think it's reasonable to implement in the month of January or February. Maybe March 1st --

MR. BENENATI: Or no later than March 1st? Remember, when we went to this one we let each agency pick their own date within a period of time. Say maybe no later than March 1st.

DR. MURPHY: That's fine. In terms of making sure everyone is on the same page, if

we say March 1st that gives everybody enough time to make sure everybody reviews and make that a date going set forth beyond that we don't use the old protocols. It should be -- Dr. VanRoekens is here now -- it should be -- I'm pretty sure it's on this agenda, the January 13th.

So want to do it again?

DR. STUTT: Sure. I move that the Hudson Valley REMAC approves the collaborative roll out for 2015 including all the changes that they recommended.

DR. MURPHY: And ask each institution or agency to start no later than March 1st.

DR. STUTT: And it's our intent that ever agency will implement by March 1st, 2015.

DR. MURPHY: I'll second that.

And all those in favor?

One, two, three --

DR. WILSON: I just arrived so I don't know if I should vote.

DR. MURPHY: Yeah. It's just to implement the new protocols for 2015 with

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those little changes, ketamine, you know --

DR. WILSON: Okay.

DR. MURPHY: -- all those in favor -- by March 1st -- and you are stepping in for Dr. Neifeld?

DR. ARSHAD: Yes.

DR. MURPHY: She just needs your name.

DR. ARSHAD: A-R-S-H-A-D I should be on the last one.

DR. MURPHY: I think it was unanimous all the way around. Thank you, everybody.

So one of the things -- you know, I'll clarify that about SEMAC and I will send out a blast e-mail after the 13th so we are all on the same page. But going forward lets make sure we have everybody on board by March 1st.

That being said, there was no SEMAC since the last November meeting, it's on the 13th so there is really nothing to report there per se.

And we are going to bring forward the IT clamp like we talked about the last time. We have -- Jeff put together a few issues,

presentations, some articles about when to use it, why to use it. It came from back as far as, I think two years ago, Mike Murphy sent to me from Rockland so we are bringing that forward.

In terms of clotting agents, that has come forward now, some of the hospitals are using them, Orange Regional came up on board with having some of the clotting agents.

So we will keep moving everything forward trying to progress the prehospital care and resuscitation and utilization of these agents. And, again, if people have ideas, things they want to bring forward, please introduce them to the committee.

MR. LA MARCA: Just a question on the clotting, the wound packing, is that within the levels as far as we are concerned as far as if we use clotting to also pack the wound with the Z foam?

DR. MURPHY: I think one of the things, should be specified on there of how are you doing it, why are you doing it, and the rational behind it, but it's all --

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MR. LA MARCA: The paramedics are doing what they are told --

DR. MURPHY: Yeah, and TSA and all those things --

MR. LA MARCA: And using expired pads, stimulator pads so if they show up in the ER.

DR. MURPHY: Yeah, to put it right over it. That's the great thing, anytime we can recycle and use them for another modality I'm in favor. What do we do with all the stuff we throw away? It's crazy in terms of quantity and stuff.

One of the things we have to make sure is we try and keep up. The 2015 protocols all had the intranasal application of all the medicines. We finally get it all standardized and we standardized the pediatrics stuff with each revision. And each time we look at these we try and get more on the same page that we have it out there for everyone so we can utilize things that have been around for a long time, we just haven't kind of adopted them. So I think it's a good thing with this

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collaborative protocols.

PAD proposals, Epipen, Albuterol, glucometer, Narcan. We don't have any proposals to be notified at this time.

We do have a Department of Health investigation and a Department of Health suspension. We have here Coling Medical Transport out of Brooklyn, New York is suspended for three years effective October 24, 2014, for violations previously issued in this stipulation and order. I don't know what that is, neither here nor there -- but Coling Medical Transport.

Open forum? Any questions, concerns?

MR. LA MARCA: Well, I know we passed over Ebola as far as nothing new per se, but it's not a dead issue and we are going to be probably actively involved in discussions at State Council. I know it for sure. But about the commissioner's orders and how they were issued, how they were impractical. But, again, that was.

DR. MURPHY: That is like the clearest thing you have ever said -- go ahead.

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MR. LA MARCA: As far as a report card on how we did in the region, county by county, relatively that's something we have to reflect on. We stumbled through to a large degree. And again, a lot of that was because the CDC constantly changes things, the State Health Department. If we really acknowledge the fact that the preparedness we needed to deal with it is not unlike what we were supposed to be already prepared to do with any bioterrorism risk we faced and they were ill-prepared. I think that is something that, you know, we got -- caught short -- I'll be blunt. And many of the agencies threw up their hands --

DR. MURPHY: I think though that you are more prepared for a bioterrorism or these other things occurring. Whereas with Ebola, it kind of threw a different wrench in the soup by saying no physical contact and no physical part of your body exposed, so that changed like from each hour. So that's where it was kind of crazy and became this thing that none of us had come across. If you look

at it there is no entity we put out there yet where we had to do such meticulous donning and doffing of our equipment and how do we do it and prepare? I don't think in my life I have ever seen a letter come down from the Department of Health that says this is what you are going to do, see ya. So that threw a big wrench, so I think it changes everything. I think you would have been more prepared if we had a bioterrorism attack.

MR. LA MARCA: That's possible, but if you think about the broad spectrum of EMS, the amount of PPE that was not either aboard units or trained to be used, I'm talking about awareness. Because we divide up into awareness and operations or technician people threw up their hands -- so we are going to have a discussion at State Council what it costs. I'm sure all the hospitals get hit with ungodly -- we got hit like 75,000 and it's ongoing. If something were to happen there was this discussion of what would the County Health Department do? What would the State Health Department do? What would the

CDC do? That should have been part of the preplan, which didn't happen, some counties did and some did not. It's the first time I know of that we had to lean on County Health more than State Health, really so much every day we don't deal with County Health, so we are under the State guidelines, State Health Department hospital system. So we are doing Article 30 and Article 28, but now County Health. It was just trying to relearn -- not relearn, but to establish a dialogue that should have probably existed. I would like to see us not let this lie.

DR. MURPHY: Be proactive --

MR. LA MARCA: And we did try and do that in the midst of the storm, but it's something we should have had already. But yeah, so I'm sure the commissioner will hear it, I'm sure we will hear at State Council. I know Dr. Dailey was out to hang the commissioner with the letters coming up. I'm sure it will be hotly contested, his orders, but orders aside --

DR. MURPHY: Dr. Berkowitz, you were on

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the phone call with the Commissioner of Health?

DR. BERKOWITZ: Which phone call?

DR. MURPHY: It was in September, that one where he wanted to talk to all of us like asap? And it was interesting because he had no real answer because people kept asking what do we do about the resources? How do we get the personal protective equipment? And then his only answer toward the end was reuse it, you are suppose to do a training every month and it was a thing of you can reuse that equipment. It's like, that is not helping for what happens when it does occur. So I have to be honest with you, we weren't getting answers.

MR. LA MARCA: But even when they sent the inspectors around I sat through a couple of the hospitals full day -- I got to see the breakfast, lunch menu -- and some hospitals got kind of like waved through. So really they sent people down who have no active experience, State, they brought people in from Rochester and Syracuse from drug

programs to do these on sites and it was like apples and oranges. So that is why I think --

DR. MURPHY: Yeah, I think it's going to be a pretty hot debated and discussed issue, especially my friend Dr. Dailey is going to be on the spearhead of that.

MR. LA MARCA: So --

DR. MURPHY: I didn't mean it was a dead issue. It was more so I don't know how much more we can talk about it. However it was -- it is a rude awakening of the possibility of things that can occur and that it is not always in our best preparedness.

MR. LA MARCA: Just my suggestion is that now that we don't have a crisis in front of us can we try and bring in the County Health officials from the six counties on a more regular basis to try with representatives of REMAC just so we are in sequence? Like I said, right, wrong, or indifferent, we largely ignore County Health. They didn't set rules of engagement, they don't do protocols unless we have a TB

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patient, but the future of the -- what our relationship should be is -- should be different.

DR. MURPHY: I think one of the places that -- Dutchess was extremely -- that was the one place that came up with protocol before anybody else.

DR. BROOKS: We met with the County Health. I wasn't at the meetings, but the directors, EMS, all the agencies were represented. It was a team with County Health that spearheaded the response, which was before the State came because we felt we couldn't wait.

DR. MURPHY: I think what he is talking about is all the other counties -- Dutchess was the most involved, but I have to agree --

MR. BENENATI: And it should have come a year or two ago. I think one of the -- this is -- I certainly learned during the process is there are agencies that don't even have blood born pathogen plans and/or the initial training that is required. And when you look at it, that's an OSHA requirement, but

because the OSHA police aren't knocking on the door every day a lot of the agencies haven't done it. And that maybe a role we need to take from an educational perspective, or send sample plans, or encourage, I think that is what Andy is saying. It might be great to invite the county commissioners here to this body for the routine meetings -- don't give them a vote -- but they should be invited, they should hear these topics, these have impact on them.

DR. MURPHY: I think we should be working together with them and sometimes we don't know who they are. But the interesting part is for all agencies they are, you know, the minimum standard of OSHA requirements that they have to have PPE equipment for all the personnel so that also comes back to integration with us, because those agencies the majority have medical directors that are going to be participating in this meeting or in our ER's per se. So we need to make sure the word gets out. We do facilitate that process and we could be more of an avenue for

information and assistance in helping people move in that direction, not punitive or regulatory, but more to try to facilitate, because everybody needs to have at least that basic OSHA requirement met.

MR. VIOLANTE: So with the Health Department -- I can't totally speak for Dutchess -- but we have been working with them with the Narcan roll out. I've been working with Jeff also they could be a tremendous resource with this body as well so perhaps facilitating that dialogue would help with the other counties.

DR. MURPHY: Maybe before the next meeting -- the next meeting is in March -- March 2nd -- we could put out a letter from the office to each one of the county Department of Health. And, also, you know, each time there is an election, that changes sometimes. I'm not sure if Orange County changed or not. I actually don't know -- is it the same Commissioner of Health who is the Department of Health for Orange County?

MR. LA MARCA: Avila.

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DR. MURPHY: That changed, I had no idea.

What would be very important too, we send a letter to each County Department of Health and just invite them. This is what this forum is, it meets four to five times a year, and that this is where it's discussed. And, you know, the ability to have that input and all of us be in the same room is extremely important too. When people ask me about this meeting sometimes I'm surprised some people don't realize it has to occur and we are here doing this and people are all in the same room.

MR. LA MARCA: I might suggest we don't send the letter out until after we see the smoke or dust settle at State Council.

DR. MURPHY: No, it's okay. We can still send out the invitation.

MR. LA MARCA: County Health helps a lot out with PPE and the State realizes where we are at, so we might get some director relief. I don't know how true it is, but once we know that maybe we can compose a letter on the

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mark with the County Health Department --

DR. MURPHY: I think also the other thing brought up is there was no vendors even available to give this stuff, the hospitals couldn't get hoods, couldn't get the right equipment. So can you imagine all these small little entities and agencies --

MR. LA MARCA: Well, the vendors actually lied in many cases and material management in the hospitals had problems with vendors who said it would meet certain requirements and the stuff didn't. So that was another issue, that people had large orders of supplies with PPE thought they scored well and found out they had to be shipped back.

MR. BENENATI: Just quick on the topic is, I don't believe the agencies are completely familiar that they need to let the hospitals know who their designated infection control officer is. Because on a daily basis you could get a phone call from them reporting a reportable disease and I bet the majority of the agencies don't even have

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their designated officer on file with the hospital infection control office. That's something the region could send as reminder, that every agency notify the hospital who your designated officer is. That's part of the Ryan White Act --

DR. MURPHY: The Ryan White Act has been around forever --

MR. LA MARCA: Except for the period where it expired --

DR. MURPHY: It was not included --

MR. BENENATI: We send it to the hospitals annually so they are current on it.

DR. MURPHY: Yeah, I think many hospitals are developing and having an EMS liaison person. And I think that's a very important person because it keeps the hospital up-to-date and hopefully has that information on board. And I think more and more hospitals or bigger medical centers are doing it and I think that is something everybody needs to be on the same page, that is no question, that communication. Even if you just had a simple meningitis come in it's

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all that -- you know, communication.

MR. BENENATI: I think it's TB more than anything else actually.

DR. MURPHY: Anything else under new business?

DR. LARSEN: Along those lines, I just was wondering what people's experience both at their hospital and with their agencies about flu affecting them? Because we have had a number of -- we've had -- at our hospital they implemented pretty strict rules about, you know, basically everyone had to get immunized. And so -- whatever -- 99.5 percent immunization rate, yet on one unit we had 10 people come down with positive flu. So that became a big thing, then I'm starting to see it in some of the EMS agencies are starting to have flu. And so in terms of developing policy the hospital basically said, if you test out positive you have to be off for I think seven days and all these rules.

So I was just wondering what people's experience with that both at their hospitals

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their emergency departments and EMS agencies?

DR. MURPHY: I don't know. Dr. Vohra, do we have an official time frame you have to be off if you test positive?

DR. VORHA: Nothing official, but as far as in the hospital if you are not vaccinated you have to --

DR. MURPHY: They are very strict on that.

DR. VAN ROEKENS: The relative point is if you are infected you are going to infect other people.

DR. MURPHY: I don't know of a policy.

DR. FAREED: Our hospital infectious disease people say three days on Tamiflu. If you feel okay, you can come back. I don't know what evidence base that is.

DR. VAN ROEKENS: CFO speaking, don't test, don't tell --

(Everyone is speaking at once.)

DR. MURPHY: Wasn't there a whole thing but how Tamiflu wasn't effective for the flu strain this year? Besides the flu vaccine --

DR. STUTT: Never was.

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DR. MURPHY: They did report that.

How about you guys?

DR. WILSON: We have got a lot of flu. And, obviously, the strain is not picked up by the immunization we have. Everybody immunized is still getting flu A.

We do have the State mandate at our hospital. However, EMS is bringing us a lot of flu cases to Northern Dutchess paramedic, but there is no mandate for taking off, just universal precautions wash and masks. The flu I've seen in the last 13, 14 years, I think it's getting a lot more people this year, more severity, maybe not the numbers, but the severity.

DR. VORHA: Then the BPA goes off and you have sepsis alert --

(Everyone is speaking at once.)

DR. MURPHY: Okay, thanks. Any other questions?

DR. ARSHAD: Transitioning to the next topic. Just wanted to gauge folks opinions on EMS long boards for acute traumatic injuries and back pain. As most of you are

aware, the tide is turning nationally and being evidence based practice certainly it's advantageous to be ahead of that curve, ride the wave rather than be behind it.

So one of my first EMS mentors, Dave Cohen, from Yale, has been successful in having Connecticut be the first state that is completely backboard free.

The evidence is fairly definitive on this and I want to just comment that this has nothing to do with my thoughts, or opinions on the C spine immobilization, that's an independent topic. But back boards even with acute traumatic fractures of the lumbar spine or thoracic offer no additional protection and are an encumbrance on --

(The speaker cannot be understood.)

DR. ARSHAD: -- and sacral ulcers forming as early as 45 minutes.

Connecticut is the first state completely backboard free and we are talking a little about collaborative protocols. The New England region has eight states that unify BLS and ALS protocols and they are

heading towards a backboard free New England. There are several cities that are completely EMS long board free, including Miami and Tampa, and LA county and LA city are backboard free, and a couple more spots. Kansas City is on the forefront. I'm spearheading one of the efforts in New Jersey state to be more evidence based and be backboard free.

This is not some rogue emergency medicine practice. There is buy-in from the American College of Surgeons, buy-in from local trauma centers. It would be of great benefit to our patients. We are in the habit of doing something because we have always done it. EMTs are afraid, you know, oh, my gosh, did they need a backboard? Well, I didn't want to be -- you know.

I wanted to plant the seed and see where people are at and just start to generate the conversation.

DR. MURPHY: Again, I'll go back to Dr. Dailey. He brought that article from American College of Surgeons and brought it

to SEMAC, but we didn't act. He brought it for information, but I don't think --

MR. LA MARCA: I think they did move forward because they emphasis it should be a transportation device, not a spinal mobilization device. And one of the physicians just asked that the nurses don't yell at the paramedics across the ER, why do you have him on a backboard? But it sounds like they moved forward to the point I thought we were supposed to have a policy change.

DR. MURPHY: I hope it's coming down, but I haven't seen anything. It's still at discretion of the provider at the scene, but it was to be utilized in terms of, do you need it to transport a long bone fracture, that is kind of the purpose, versus say, really not an immobilization device.

MR. LA MARCA: Because it moved forward to hold harmless --

DR. MURPHY: Yes, definitely hold harmless, but nothing in formal writing.

MR. HUGHES: Didn't they create a TAG to

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look --

MR. LA MARCA: There was a TAG that operated for --

MR. HUGHES: I understood but they asked the TAG to report at the next meeting.

DR. MURPHY: I'll bring it up at the next meeting at standards.

(Everyone is speaking at once.)

DR. MURPHY: What we said in the collaborative agreement was to make sure people realize they do not have to use it, it's not mandated and doesn't help. It actually hinders. And when you have all the trauma people coming forward to say, get them off the backboard as soon as possible, walking to the bedside to get them off the backboard, that's different from cervical spine immobilization, that's a different entity.

MR. BENENATI: I think Dr. Ahmed said we have to be prepared for the next REMAC meeting in March.

(Everyone is speaking at once.)

DR. ARSHAD: You threw me off with the

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Dr. Ahmed, that maybe my cousin but --

MR. BENENATI: Dr. Arshad --

DR. ARSHAD: -- I have literally protocols that are already written that I'm employing in New Jersey State. We have been in touch with EMS medical directors in LA, so we are on the tipping point. This is something that as local hospitals the way I would like to build muster is talk to the trauma folks. We are not trying to do a sneak attack on anybody, you know, this is evidence based.

DR. MURPHY: The trauma guys are right on. They are the ones yelling the -- I'll investigate at the SEMAC where that is at and what we can do to put it on the agenda for March, that we move forward in the interim. Let's start spreading the word and see what is out there and make sure people know they are held harmless, change the way people look at things. I think it's educational for our nurses and department that they realize that the new evidence based is telling us --

DR. ARSHAD: It's January 5th -- 4th,

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let's plan to see and let the snowball roll.

DR. BERKOWITZ: I think at some point there needs to be advisory. The biggest problem is a cultural problem that we have talking with the nurses and even some of the older physicians, both ER, trauma surgeons, who maybe haven't read the evidence. You are not going to make anything happen until they are made aware and, you know, something that was, you know, agreed upon by the SEMAC that people could post in the OR for all the nurses to read and all the doctors to read, post outside the resuscitation room so the trauma surgeons would see that too would go a long way to getting people to think about it. Because right now a lot of those people aren't reading the literature you are referring to so it doesn't make a difference even if you pass a law, even if you change the standard, to them they haven't seen the signs so they are going to think it's something else.

MR. LA MARCA: I also think that over the years of training EMS if you looked, the

one sacred doctrine was the immobilization of spinal injuries. You can find differences in class all over, but they were preaching and hammering at that for years. So much so that you go to the ER and cut the straps off, whip them off the board, oh, my god -- but I think it will take awhile.

And somebody said advisory, I think they move now more by advisory. I don't see a reason REMAC can't put an advisory already for our region. We know the intent of the State, we know the standards and the trauma centers are supporting it, why not have REMAC put out the --

MR. VIOLANTE: I second.

DR. MURPHY: I'm okay with that, yeah. Do you want to vote on -- do we have to vote on advisory or put it out -- all those in favor? Would that be something you want our name to that we vote as body that would be a good thing to start in our area and get the word out and start moving people in the direction of being back boardless.

DR. WILSON: I need to be the first

person to say I need to read more about this.

DR. STUTT: I think it would be better supported if we had literature to share.

DR. BERKOWITZ: Write the advisory and review it and say this sounds really good. It sounds like you have --

DR. ARSHAD: No problem.

DR. BERKOWITZ: It sounds like it's actually in your bag right now.

DR. MURPHY: What did they do with the course, the no STLS course? They talk about it in the STLS manual, but I didn't know about it.

Okay, we will put together the articles, send it out with a draft of an advisory, have everybody look and get back to us, feedback. And then we can launch it after a good presentation next meeting.

DR. BERKOWITZ: Even if it just says this is no evidence, even advisory, that you do not make recommendation. It just says you know, everyone in the region, we just want you to know that this practice we have been saying is really important, there is no

evidence to support it. Even advisory, people -- I think honestly nurses in my hospital, jaws would just drop.

DR. ARSHAD: Sticking with the punitive aspect from prehospital providers there is many cases where you guys, medics, are going to be more evidence based. We want to promote you to be the best you can, take away any danger or fear or repercussions.

DR. MURPHY: Sounds good. I think the other thing that is very important is the hold harmless. I'm pretty sure that passed.

MR. LA MARCA: They did.

DR. MURPHY: So that's important for people to know.

Any other open forum new things?

We did get a letter from Dr. Bennek from Sharon Hospital, they are changing their group so he resigned as of January 1st. The new group will forward us his replacement and thus a new participant for the committee, but I think everything else said stayed about the same.

Any other info? Anything anybody wants

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to bring up?

Guests in the back, you are awful quiet today.

Okay, thank you, everyone. I make a motion to adjourn.

DR. BROOKS: Second.

DR. MURPHY: Thank you all for coming.

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

Yvette Arnold