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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 Tuesday, March 2, 2015 at 9:30 a.m.

Debra Boggs,
Court Reporter

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

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4 DR. PAMELA MURPHY,
Committee Chair

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DR. ERIC STUTT,

6 HVREMSCO Medical Director

7 WILLIAM HUGHES, EMT
HVREMCO Executive Director

8

JEFFREY CRUTCHER, QI Coordinator

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ST. FRANCIS HOSPITAL

11 DR. ARSHAD, Director

12 WESTCHESTER MEDICAL CENTER
DR. ERIK LARSEN, Physician Representative

13

SHARON HOSPITAL

14 DR. RICHARD BENNEK, Physician Representative

15 GOOD SAMARITAN HOSPITAL
DR. DENNIS MAO, Director

16

PUTNAM HOSPITAL

17 DR. BUTTERFASS, Director

18 VASSAR BROTHERS MEDICAL CENTER
DR. BERKOWITZ, Physician Representative

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ALSO PRESENT:
ANDY LAMARCA
DAVID GRASS
ERNIE STONICK
KEVIN GAGE
RICHARD ROBINSON
RICHARD PARRISH
ISRAEL KNOBLOCH
MICHAEL BENENATI
JASON CONWAY
TIM HUTCHINSON
BOB CUOMO

1 Proceedings
2 DR. MURPHY: We will bring the meeting
3 to order and add people on as they come.
4 Because we don't have a quorum we won't vote
5 on the minutes at this point, but please,
6 make sure you review them for the next time
7 and we will just double it up.
8 This morning thank you all for coming in
9 this weather. It wasn't -- everybody thought
10 it was going to be bad. It was nothing out
11 there right now. The roads are really good.
12 So, this morning we just want to, you
13 know, under old business, make sure everyone
14 keeps in mind that the projected date for
15 everyone to be done with their rollouts is a
16 reminder that it's March 15. So, it's going
17 to be coming up quickly, just make sure
18 everybody gets their ducks in a row and all
19 of the information out there. It was sent
20 out from the office along with the exam. And
21 I just hope everybody has it up and going
22 and we're all on the same page by March 15
23 all together.
24 Thank you, again, to the whole committee
25 that helped with the collaborative rollout

1 Proceedings
2 and making sure we get all of the information
3 out there and that we had it in an orderly
4 fashion. And again, the protocol committee
5 and really the collaborative committee I
6 thank you all personally.
7 BLS Naloxone rollout update?
8 MR. HUGHES: Just to keep you informed,
9 in 2014 we did 867 administrations. So far
10 in 2015 we did 96 administrations. That
11 includes ALS on those numbers also. And the
12 number of reported reversals is 27 in '14 and
13 three in '15. And right now this year so far
14 we have done three CBO agencies through our
15 office, so the program is moving along.
16 DR. MURPHY: All right. Thank you.
17 One of the things we had brought up at
18 the last meeting and just kind of touched
19 upon it with an introduction and we said we
20 would come back to it, and this morning,
21 Dr. Arshad, I'm going to turn the meeting
22 over to you to talk about spinal
23 immobilization. And one of the things that's
24 happened since I spoke to you is STAC has
25 tabled the topic, so the floor is yours.

1 Proceedings
2 DR. ARSHAD: Absolutely.
3 So, I guess we start out by saying this
4 is a topic that remains to be controversial.
5 Nevertheless, having just returned from the
6 Eagles conference in Dallas it is something
7 that is on the national agenda. And in
8 regards to the preponderance of evidence that
9 continues to be developed we have a good 25
10 to 30 papers that are evidence based. We
11 have national guidelines from the National
12 Association of EMS Physicians and the
13 American College of Surgeons, ACS, and ASAP
14 has just released their new plan for policy
15 and guidelines regarding rigid spinal
16 immobilization.
17 I personally am of the opinion that
18 going forward it's almost unethical to
19 continue to provide rigid spinal
20 immobilization because of the harm that is
21 very clearly evident in regard to the
22 process.
23 So, just a bit about the concept, yet if
24 I break my femur I splint from the joint
25 below to the joint above and provide

1 Proceedings
2 stability which increases patient comfort.
3 The spine in itself, as we very clearly know,
4 is a curved anatomic shape and is not
5 predisposed to effective immobilization on a
6 rigid spine board. Evidence thus far
7 significance worsening outcomes in regards to
8 functioning residual capacity patients are at
9 high aspiration risks. In fact, because it's
10 a glossy surface there have been studies that
11 show there is in fact increased mobilization
12 when people are on the spine board in
13 comparison to the EMS cot.
14 And then certainly elderly comorbid
15 patients who have fallen in nursing homes are
16 predisposed to forming pressure ulcers
17 within 45 minutes of being on a long board.
18 And we've all had experiences and encounters
19 where patients are two hours, three hours,
20 four hours we fail to clear them in the
21 emergency department.
22 So, it is certainly something that is on
23 the national agenda and is being pushed. As
24 mentioned, New Hampshire was the first state
25 to go completely long board free.

1 Proceedings
2 Connecticut was the second state. I had an
3 opportunity to speak at length with the LA
4 EMS medical director, Dr. Mark Eckstein, as
5 well as several medical directors from
6 Florida. There are cities and counties
7 including LA, Tampa, Miami are essentially
8 all long board free.
9 And there is tremendous amount of
10 collaborative videos and protocols that are
11 coming out of Kansas City under the
12 leadership of Sebina Greatwait [ph]. So,
13 it's something that is continuing to be
14 discussed. There is marked buy in from the
15 surgeons themselves.
16 And I had written a draft protocol for
17 us to review, I don't think we're quite at
18 that stage yet. But I think there was
19 Dr. Murphy's specific feedback from
20 neurosurgeons who were concerned with it.
21 Can we just air that out? Because I, in
22 fact, got in touch with my mentor, Dave
23 Cohen, in Connecticut who was like that's a
24 new argument for me. We don't have any
25 issues with neurosurgeons in Connecticut or

2 New Hampshire.

3 DR. MURPHY: Yeah. That's what they
4 said at SEMAC and why it was such a big deal
5 that STAC did not move forward on it. The
6 people in the room -- I was not the meeting.
7 This is what I was told. The people in the
8 room that had -- were not in favor of getting
9 rid of it was the neurosurgical contingency
10 on STAC.

11 DR. ARSHAD: We don't know why?

12 DR. MURPHY: Yeah.

13 DR. ARSHAD: So, in our Dutchess County
14 meetings with Arlington, LaGrange we were
15 trying to parce that out a little bit more
16 and it seemed we were unable to see what
17 specific medical issue they had concern with.
18 Because the evidence now is overwhelming.

19 I presented a CME on this topic three or
20 four nights ago. And the parallel I drew was
21 if long boards were a drug the FDA would have
22 long banned them.

23 So, again, regarding the ethics of do no
24 harm especially in the pre hospital
25 environment is something we should continue

1 Proceedings
2 to discuss. One thing that -- a nuance that
3 we had maybe unearthed was while they had
4 tabled the issue, they recommended that
5 individual regions who wanted to pursue a
6 non-punitive strategy should be able to
7 continue to do that. So, I'm not sure if we
8 had guidance with regard to that or if you
9 guys heard this.
10 DR. MURPHY: I think that you see more
11 and more of it that across the country the
12 papers are coming out that it's definitely
13 something to do. I was shocked when she told
14 me that they brought it up that STAC had, and
15 that's why they tabled it, because there was
16 so much controversy and I guess the biggest
17 contingency that was saying we couldn't just
18 get rid of back boards was not there, so
19 that's why they tabled it.
20 DR. ARSHAD: I got you.
21 DR. MURPHY: And it was right before
22 SEMAC, the day before SEMAC. So, like
23 Dr. Daily, who is part of our collaborative
24 thing, who is so anti-backboard, could not
25 make the meeting because they didn't tell

1 Proceedings
2 him. Well, they told him but it was last
3 minute, so he couldn't get there.
4 So, one of the things that also came up
5 was that they make sure that STAC meetings
6 are publicized enough time in advance so that
7 people could get there. Because I will go
8 too. I'm going to start going to the
9 meetings. I won't be a voting member but
10 he's a voting member.
11 DR. ARSHAD: So, what do you all want to
12 do about it?
13 DR. MURPHY: I think that everybody
14 should take a look at the draft protocol. We
15 still gave it out to everyone. And I think
16 that we need to definitely be moving in that
17 direction of looking at this from a real
18 perspective.
19 The problem I think is going to be if
20 the State protocol keeps it we can't get rid
21 of it, right?
22 MR. LA MARCA: But actually CMAC did
23 pass the approval of the protocol.
24 DR. MURPHY: Yeah. They want to move
25 forward.

1 Proceedings
2 MR. LA MARCA: So, the TAG did report.
3 So, that's actually why I was coming today to
4 ask for an advisory. Because as far as we're
5 seeing the hospitals are already reacting to
6 this that they don't want the patients on
7 backboards. We're having crew issues. So,
8 my take is that if CMAC did approve --
9 DR. MURPHY: If State protocol still
10 says backboard don't we still have to follow
11 that or no?
12 MR. LA MARCA: State protocol, no. I
13 don't think so. Because we already had an
14 action by CMAC. I think they're just waiting
15 for department to put it in, you know, as far
16 as the formal protocol.
17 Clearly the 2008 updated spinal protocol
18 that is on the website is trash. So, I
19 personally I think we're at a crossroads
20 right now --
21 DR. MURPHY: Because Dr. Young --
22 MR. LA MARCA: -- what the state is
23 going to do and that takes time, but the
24 hospital is already reacting to it. They
25 don't want the patients on the backboard.

1 Proceedings
2 Crews are coming in.
3 One thing that CMAC did do, last time
4 was again the statement as repeated here in
5 the protocol, "backboard is one of multiple
6 modalities that can be used to minimize
7 spinal movement. Electing not to use a
8 backboard will not constitute a deviation
9 from the standard of care, so I think we have
10 coverage in that respect.
11 DR. MURPHY: And they talked about how
12 you can use it to move a person if you want.
13 Like if you feel you have to use that hard
14 board to move somebody, but you get them off
15 the board. And not to equate cervical spine
16 immobilization with a backboard, that was the
17 other big point.
18 DR. ARSHAD: So, let me clarify the way
19 I've written this protocol. And it is
20 certainly evidence based. And it takes into
21 account all of these various concerns just
22 from having conversations with medical
23 directors at a national level.
24 So, the long board, it's not like we're
25 going to have a tag sale, you know, get rid

1 Proceedings
2 of all of the long boards.
3 MR. LA MARCA: Firewood.
4 DR. ARSHAD: Exactly. Who knows what
5 that will do to the ozone.
6 DR. MURPHY: Recycle.
7 DR. ARSHAD: Long boards should and
8 could be used for patient extrication
9 purposes. But the science comes down to if,
10 in fact, we're getting prepared for
11 transportation the EMS cot provides a greater
12 amount of spinal immobilization than in
13 factors of rigid spine board. So, certainly
14 if you have a multi trauma patient that is
15 unable to ambulate, unable to transport then
16 that still warrants transport with an EMS
17 long board. For the great majority of
18 patients you can use it as an extrication
19 device and have them either self transfer or
20 transfer to the cot and then pull the board
21 out from underneath.
22 Reverse take downs are in my opinion
23 frankly unethical. There are so many bad
24 things about this. If a patient is
25 ambulatory on scene you can certainly make

1 Proceedings
2 the determination to place a C-collar. This
3 is independent. We're talking about
4 selective rigid spinal immobilization. If a
5 patient needs a collar, we will have that
6 debate in about a year. But we're not quite
7 there yet. And we're going to discuss the
8 issues separately. That's probably
9 politically the better way to affect change.
10 Certainly reverse take downs are unethical.
11 And then the third point is for
12 penetrating trauma. For penetrating trauma
13 there is almost never an indication to use
14 rigid spinal immobilization. So, that's
15 something we need to start.
16 DR. MURPHY: It's just really, it's a,
17 you know, it's a change in just like --
18 DR. ARSHAD: Dogma.
19 DR. MURPHY: Yeah. It's been there
20 forever. It was kind of like when amiodarone
21 first came out and we thought about not using
22 Lidocaine, you know, that was the same kind
23 of thing. When vasopressin came out and we
24 thought something other than epinephrine.
25 So, it's all of these things that are --

1 Proceedings
2 DR. LARSEN: At least amiodarone had a
3 lot of money behind it.
4 (Everyone speaking at once.)
5 DR. MURPHY: Point well taken.
6 DR. LARSEN: Someone should have
7 invented an alternative to long boards that
8 cost a lot of money. An expensive sheet.
9 DR. MURPHY: Biodegradable long boards.
10 DR. LARSEN: One thing is, just looking
11 over my calendar, the RTAC is going be
12 meeting, the Hudson Valley Regional Trauma
13 Advisory Committee, is going to be meeting on
14 the, I guess, it's Friday the 13th of March
15 at Good Samaritan. Okay.
16 DR. MURPHY: Do you know the time?
17 DR. LARSEN: Yeah. 9:30 to 12 is what I
18 have. So, March 13 is the --
19 DR. MURPHY: Can you be there,
20 Dr. Arshad?
21 DR. LARSEN: So, I think, you know, this
22 needs to be a major agenda item there. I
23 plan to be there at least for part of it.
24 But I think it needs to be pushed. And at
25 least if we're getting resistance from the,

1 Proceedings
2 you know, from the surgeons on a State wide
3 level we need to push it up for the regional.
4 I don't know, maybe there is no resistance.
5 But we should consolidate what's going on,
6 this discussion, within the region.
7 DR. MURPHY: Do you remember Dr. Young,
8 he was getting hot about it, you know.
9 MR. LA MARCA: I really don't think that
10 overall there is any objection. Again,
11 they're really emphasizing rigid collar and
12 minimize movement. And now you're talking
13 about board other than it being one way to
14 move somebody. But against any take down no
15 board, nothing like that. I think everybody
16 is going in the same direction. I think the
17 hospital, as you said, by evidence based
18 medicine move in that same direction. And
19 now we're having, not a conflict, but now
20 we're having the fact that EMS is saying we
21 haven't been told to go. We understand we
22 haven't been told to go yet. But I think we
23 need some coverage from this body, whether
24 it's an advisory or not, because I think we
25 have to move forward and give our EMS field

1 Proceedings
2 providers the okay to go ahead and do what we
3 know we should be doing. The only problem we
4 have, quite honestly, is that the State takes
5 forever for the protocol. And it takes even
6 longer for us to get the damn stuff out of
7 the curriculum, and the training and the
8 testing. Right now we have -- one of the
9 practical skills station they all take right
10 around that backboard. And then we have the
11 State exam right around that backboard. So,
12 our only problem is that, you know, that's a
13 little dilemma we have and really our
14 educators are really handcuffed in the
15 classes right now. Because they're going
16 into these classes this semester saying they
17 probably shouldn't be use backboards but by
18 curriculum and by the State requirements they
19 have to train them to use it.
20 DR. MURPHY: Right. It's still there in
21 a big part.
22 MR. LA MARCA: I just think --
23 SPEAKER: I don't think we can stop what
24 we are doing to move forward for practice
25 because education is lagging or the political

1 Proceedings
2 system is lagging as that back up. I think
3 if we have CMAC approval here that's pretty
4 good to move forward.
5 DR. MURPHY: We voted on it and that is
6 our desire to move forward. However, I have
7 to tell you, Dr. Young from the State, he was
8 like red in the face and got up from the
9 table. It's a thing. They went back to this
10 thing of they're going to -- they want -- the
11 State wants to follow what STAC says and so
12 because there was so much back and forth
13 STAC, what I got on the last thing, they
14 tabled it. But I think, you know, it only
15 behooves us to move in the direction of
16 what's the right thing to do. And I agree.
17 We can't hold up proper care and doing no
18 harm just because people are slower in the
19 forces of bringing it along to catch up.
20 And I think it's going to be confusing
21 for the people coming off of new training or
22 new medics coming out. We just spent six
23 weeks on learning about backboards and take
24 downs and strapping, how to strap them down
25 to this thing, and now we're not going to use

2 it. So, it's going to have to be something
3 we will have to work very heavily on. But I
4 think it's something that we have to do. I
5 don't think we can just ignore it.
6 MR. LA MARCA: I think honestly EMS was
7 for evidence based medicine and by medical
8 over liability. And I think right now we
9 have evidence based medicine that's proven we
10 shouldn't be using them. And now we're going
11 to have increased liability if we do wind up
12 using them and somebody wants to make an
13 allegation that we had this knowledge, we did
14 something that may have provided harm to the
15 patient. So now I think it's thrust upon us
16 that it we might be more liable.
17 DR. ARSHAD: So, one of the aspect I
18 discussed was what is the origin of the
19 policy, why has it become common practice
20 among all EMS agencies across these 50 great
21 states. And it was policy that was developed
22 in 1968. And it was two cases, two cases in
23 a pre hospital space were cited to develop
24 these policies at large, and I reviewed this
25 all in my CME. One case was a patient with a

1 Proceedings
2 depressed skull fracture who later developed
3 neurologic disabilities. And another was a
4 patient with a gross T-5 like transsection
5 that upon pre hospital evaluation had
6 neurologic deficit. So, these two cases in
7 1968 were used to develop this policy of
8 rigid spinal immobilization. It was a time
9 of great change and it rapidly got picked up
10 without an appropriate evidence base.
11 DR. MURPHY: That's a time when the
12 whole push was for us to go to the scene of
13 the accident and help people.
14 DR. ARSHAD: When we were transitioning
15 from hearses to ambulances.
16 DR. MURPHY: Yeah. That was when the
17 NTSB and the national traffic and safety
18 stuff started happening.
19 So, we actually do have a quorum now.
20 Because we have seven. And there is six that
21 are not here.
22 DR. LARSEN: I'm not.
23 DR. MURPHY: I got you. So we could
24 vote on an advisory. If you guys wanted to
25 put an advisory forward. How does the

1 Proceedings
2 committee feel? I'm in favor of it. But
3 it's not a one-person show here.
4 DR. STUTT: How would that fly in the
5 face of the CMAC's position right now? That
6 has not been resolved --
7 DR. MURPHY: CMAC is resolved. It's
8 STAC that was not resolved. STAC is an
9 advisory committee. Again, CMAC is supposed
10 to be really the person that oversees all of
11 it with input from all of these places. But
12 I think as a region we can protect our people
13 by saying this is the direction we're moving
14 in and I think it's going to happen. I just
15 think that -- I think Andy has a very valid
16 point that we need to protect our providers.
17 This is what we are here for. We're here
18 really to be the advocate for the people in
19 the field, and say this is proper care, this
20 is what we should be doing.
21 And I think just like other advances in
22 medicine, I think my feeling is we should be
23 helping them and supporting them and say we
24 would, you know, hold them no harm not to use
25 a backboard. I think that it's a same kind

1 Proceedings
2 of process. And we can use the same verbiage
3 that we have in the CMAC draft.
4 MR. LA MARCA: Just to be clear CMAC had
5 put the seconded motion up and SEMSICO
6 approved it.
7 DR. MURPHY: Okay. I don't go to
8 SEMSICO so that's another positive finding in
9 our behalf, that this is going to move
10 forward. So, I think there are going to be
11 some lags with education. There are some
12 lags with the policies and such. But I think
13 I would rather be on the front end of the
14 wave than not catching the wave. Because I
15 think this is solid evidence, solid stuff.
16 We've all been doing it. And people are
17 looking at us like we're crazy, but I think
18 it's time to move forward and have New York
19 catch up.
20 DR. ARSHAD: Certainly it's beneficial
21 to be on the leading edge of things. We just
22 carried momentum, drive passion among our pre
23 hospital care providers. People are so
24 excited at the CME on the topic.
25 Just to give you a flavor of the rest

2 the country. When they polled like 5000
3 attendees at Eagles all across the country
4 how many people are backboard free, about 30
5 percent of folks raised their hand, and how
6 many people planned to be backboard free
7 within three months a good 60 percent of the
8 folks. It's certainly a national trend.
9 Pre hospital care providers are
10 concerned about liability. You bring up an
11 excellent point, sir, that in fact, the
12 evidence tipping point is going the other
13 way. So, you may be actually open up to more
14 liability by boarding a patient who is
15 ambulatory -- there is great momentum and it
16 we will be safe especially giving the CMAC
17 and SEMSICO.
18 DR. LARSEN: One question, what did the
19 American College of Surgeons say on this?
20 Because we can --
21 DR. ARSHAD: Absolutely. The guidelines
22 they have are published in conjunction with
23 NAMSB, which are middle of 2014. And they
24 all said the same thing, get rid of long
25 boards.

1 Proceedings
2 And in regards to an emergency medicine
3 practitioner, I feel I know a lot more about
4 generalized trauma and multi trauma than
5 specifically a neurosurgeon does.
6 DR. LARSEN: Right. I mean but we have
7 their paper, their guidelines --
8 MR. ARSHAD: Their policy guidelines --
9 DR. LARSEN: -- if there are a few folks
10 out there in the surgeon audience that are
11 saying woh, woh, woh, I think we have the
12 evidence for it. I think we should move
13 ahead.
14 MR. LA MARCA: I think if somebody is
15 going to try to sue us for what we are doing
16 using the boards, they are going to use those
17 papers. And so why don't we use them and do
18 what it says.
19 DR. MURPHY: I think that it's a thing
20 where most of it is education and people just
21 not realizing it.
22 And one of the things I'm going ask
23 Dr. Arshad is there a couple of EMS
24 conferences coming up in the region and I
25 want to give you the dates to see if you are

1 Proceedings
2 around, maybe you can do your CME there. And
3 that way we get the word out, this is what
4 we're talking about, this is why, this is
5 where it came from.
6 DR. BENNEK: On the Connecticut side
7 that rollout has occurred. And the biggest
8 steps of resistance is the tradition of
9 having to use the backboards. People are
10 very, very nervous about making the
11 transition for the liability issues and
12 everything else. So I thing getting ahead of
13 that is a good idea.
14 DR. MURPHY: I think it's more in the
15 people that are out there on the volunteer
16 side that are not as much on the, you know,
17 connected to this meeting and such. And so
18 they don't hear it. And all of a sudden they
19 come into the ER and people are yelling at
20 them that they're using a backboard and
21 they're like what. So, it is an eye opening
22 kind of new thing that people are not really
23 thinking about. So, I think the more we get
24 the word out there and it would be good for
25 us to try to move forward.

1 Proceedings
2 MR. LA MARCA: A number of us that have
3 been involved in EMS education for countless
4 years had the discussion, and pretty much
5 we've come to believe one thing, and that is
6 out of the thousands of EMS courses that have
7 gone throughout the state, some who can't
8 teach blood pressure and some who can't do
9 other things, they all did teach the fear of
10 God for not putting somebody on a backboard,
11 so that was the only thing we found that was
12 all taught the same. And now we're going to
13 have to try to back this thing up.
14 DR. MURPHY: I did get to see a video
15 somewhere, and I won't say where it was, of
16 two students strapping someone to a backboard
17 in a realtime class, let me tell you, that
18 backboard needs to go away. When I saw what
19 he looked like afterwards I was like oh, my
20 goodness.
21 DR. ARSHAD: I will forward you some
22 videos that were developed in Kansas City.
23 And they're meant for general public EMS
24 consumption. So, I will forward them to you
25 and if you think they are worthwhile you can

1 Proceedings
2 forward them to the group.
3 DR. MURPHY: Okay. Do you want to --
4 Can I make a motion? And let me know if
5 this is something you all agree to, a motion
6 that we develop an advisory based upon what
7 Dr. Arshad has put here, and that it has nice
8 definitions in it, the indication why we
9 don't need it for penetrating trauma, what's
10 the point with blunt trauma, and basically
11 you know, it's a nice well written -- and
12 thank you -- advisory in draft form that we
13 could talk about using. I know some of you
14 didn't get to read it until today. But I
15 would love to, instead of having to wait make
16 a motion that we promote the advisory in our
17 region to protect our providers and maybe we
18 just add that one sentence in here, that we
19 will stand behind and hold without harm
20 anyone who, you know, utilizes this protocol
21 or this advisory due to the fact that, you
22 know, evidence based medicine is coming out
23 to show us that we've been doing something
24 wrong for a very long time.
25 MR. LA MARCA: This is the one they

1 Proceedings
2 caught.
3 DR. MURPHY: Exactly.
4 Does that sound okay?
5 DR. ARSHAD: I will second.
6 DR. MURPHY: All of those in favor?
7 (People in the room indicated.)
8 DR. MURPHY: So, that's unanimous. We
9 will add in that one little part and go from
10 there.
11 Thank you for all of your work,
12 Dr. Arshad.
13 DR. ARSHAD: My pleasure.
14 DR. MURPHY: Service upgrades, there is
15 none today.
16 Evaluation Sub Committee. Dr. Brooks
17 couldn't be here today. But we didn't have
18 any issues, there was none that was put
19 forward.
20 DR. STUTT: No.
21 DR. MURPHY: Helicopter committee
22 report. Did we hear from Stuhlmiller?
23 MS. LEONE: He can't make it.
24 DR. MURPHY: There was no meeting since
25 the last --

1 Proceedings
2 DR. LARSEN: There has not been one.
3 DR. MURPHY: There was no meeting.
4 SPEAKER: Dr. Murphy, at the last
5 meeting this group approved the protocols for
6 the helicopter, and we haven't seen them
7 distributed. So, maybe somebody could follow
8 up and get them distributed.
9 MR. HUGHES: I do have an update on
10 that. There are two regions involved in
11 those protocols and we're still waiting for
12 Westchester to approve them.
13 DR. LARSEN: The problem was we got hit
14 by three snow storms in a row that we
15 canceled our meeting. And then postponed it
16 over until next week. So, we haven't had a
17 meeting. We missed a whole meeting because
18 it was --
19 SPEAKER: You need to change your
20 meetings to Tuesdays.
21 DR. LARSEN: Right. Next year we will
22 do that. But anyway, so we haven't met and
23 so we're way behind on a bunch of stuff. So,
24 I apologize for that, but it was local
25 conditions.

1 Proceedings
2 DR. MURPHY: Imagine the poor people in
3 Boston.
4 So, that will then after that -- Mike,
5 we will make sure we get it put out. I put a
6 note for myself and go forward.
7 Quality improvement report. Jeff.
8 MR. CRUTCHER: We've had some movement
9 with EPCR's and the move to NEMSIS3 [ph].
10 Image trend has had to put their new platform
11 on hold. They have deemed it unstable with
12 all of the additions that they've been
13 putting onto it for requested reports. So,
14 they decided that rather than release a
15 product that wasn't ready they will hold off
16 and get all of the issues fixed.
17 DR. MURPHY: Under new business there is
18 it a plethora of medication shortages again.
19 You know, I don't even know what to say.
20 It's just this thing where, you know, we have
21 these people sending us in lists that we're
22 trying to tabulate and keep track of. But
23 it's, you know, this report is from one
24 supplier. Some other people might be
25 different. But it's like impressive the

1 Proceedings
2 number of drugs that are on there. So,
3 again, what were going to have to do is try
4 to be flexible, try to have alternatives
5 there for people to use. And hopefully be
6 patient that things will come back. The list
7 here, I'm not going to read off a list of
8 medications that are shortages, but it's
9 crazy and most of them are like really basic
10 drugs, you know. And as you know, if you're
11 working in the hospital now antibiotics are
12 under that realm. We can't get Zosyn
13 anymore. We can't get -- Unicin just joined
14 the list. So, these basic penicillin type
15 antibiotics. So, I don't know what to say
16 other than that we have to have an
17 alternative. We have to make sure that
18 people have things they can use and realize
19 that there is going to be this ongoing
20 onslaught of medication shortages.
21 DR. STUTT: Hudson Valley REMSCO met
22 February 4 and a couple of issues that might
23 be of interest or should be interest of this
24 party is that there was a significant
25 discussion about the coordination of EMS

1 Proceedings
2 services and responses throughout the whole
3 region. And this is precipitated by the EVD
4 preparation that everybody had gone through
5 and recognizing some of the problems.
6 New York State is under the assumption
7 that there is great communication with all of
8 the regions with all of the counties within
9 the regions and with all of the regions. It
10 doesn't seem to be evident that there really
11 is that kind of communication. President of
12 the EMS counsel, Mr. Michael Witkowski and
13 Executive Director, Bill Hughes are trying to
14 establish a tag to get that kind of
15 communication going throughout the region.
16 Particularly including the health
17 commissioners of each -- the health
18 commissioner directors of each county as an
19 integral part of that organization. So, we
20 should be hearing more about that. And that
21 was one of Andy La Marca's concerns that we
22 include the health commissioners for that.
23 In January, early January a bill was
24 placed before the New York State Commissioner
25 of Health regarding permission or approval

2 for advanced EMS providers to transport blood
3 products during care of a patient. I believe
4 that's still pending unless Andy has some
5 further updates.
6 MR. LA MARCA: Still awaiting signature.
7 DR. STUTT: In your packets it was
8 mentioned at the REMSCO meeting and now
9 presented, New York State Policy 1401, which
10 all of you should have which -- this is
11 particularly important because many of us
12 here are agency medical directors, all of us
13 are members of the REMAC and it is a very
14 detailed, thorough and thoughtful approach as
15 to how to do remediation of medics who are
16 not meeting the standards that the medical
17 directors recognize as important. And it's
18 detailed about who has to be reported, how to
19 do the reporting, how to follow up on it and
20 how to involve the REMAC and the region for
21 all of that. So, I think it could be very
22 helpful for all of us to give some clarity
23 about how to approach improving the quality
24 care out there.
25 DR. LARSEN: What's the policy number?

1 Proceedings
2 DR. STUTT: 1401.
3 DR. MURPHY: I think just like all of
4 these bodies and entities, the only way
5 things happen and that we stay on the same
6 page is that the information kind of
7 disseminates and kind of moves outward. And
8 that's our responsibilities here. It kind of
9 segues into our responsibility to bring this
10 information back to each one of our medical
11 control facilities and the agencies we belong
12 to and that we serve with and to just make
13 sure that information is disseminated. All
14 of these things are so important that we do
15 but it doesn't work unless we do communicate,
16 so that kind of brings further to the front
17 that we have to make sure that we do that.
18 Andy, anything else from SEMSICO?
19 MR. LA MARCA: The only thing that they
20 had -- well, they had a couple of different
21 motions. One was that CPAP was added to the
22 adult -- protocol for BLS, and that would be
23 something that the BLS service wants to get
24 involved and use the CPAP they will come here
25 again. They approved the State medication

1 Proceedings
2 formula without dosage ranges or
3 indications --
4 DR. MURPHY: Oh, that's right. That was
5 a big one.
6 MR. LA MARCA: It was a big one. But in
7 light of the meds you can't use --
8 DR. MURPHY: So, basically they came out
9 finally with a whole formulary for the State
10 so it has the medications on there.
11 What we ask though was it was in such
12 detail, it was almost like a pharmacology
13 text. It had indications, interactions, all
14 of these things for each one of the drugs and
15 specific dosages. And what we ask was just
16 like any formulary it would be better to have
17 them labeled rather than such specific
18 guidelines that would have to be changed all
19 of the time, would have to be updated all of
20 the time rather it would be good to have a
21 formulary with a list and let the regions put
22 in their protocols the exact dosages and
23 things like that rather than it coming from
24 the State. So, we approved it removing that
25 part of it.

1 Proceedings
2 MR. LA MARCA: Another things is for New
3 York City brought up for an emotionally
4 disturbed patient they had the protocol pass
5 to allow midazolam on standing order for a
6 crisis situations.
7 And actually following onto that one,
8 they allowed a motion was seconded and passed
9 by the body allowing protocols that are
10 approved by CMAC to be utilized by other
11 regions within the usual 30 day notice to --
12 excuse me. With the usual 30 day notice of
13 the department. So, what they're saying is
14 if you want to adopt somebody else's protocol
15 that's already been passed you can do so
16 within it's entirety without having to go
17 through the entire process that we have to go
18 through the change protocol. So, something
19 like the midazolam was indicated, we would be
20 able to almost use it, I don't want to say
21 cart blanc, but once we send the
22 documentation up we can use it.
23 MR. HUGHES: We still have to go through
24 the regional approval, which puts out a 30
25 day comment period and then address the

1 Proceedings
2 comments when they do come back and then move
3 on to something else.
4 MR. LA MARCA: We don't have to wait for
5 the State.
6 DR. MURPHY: It shortens -- right. It's
7 so much better -- especially if something was
8 approved it only makes sense that why does
9 another area have to come and go through the
10 full approval process again. So, we're
11 trying to streamline everything and make it
12 quicker.
13 MR. LA MARCA: Suffolk County EMS pilot
14 project will allow an EMT the use of a single
15 unit to provide an airway during adult
16 cardiac arrest. They have to have two BLS
17 providers, one has to be an ENT and the other
18 could be a CFR. Again, they have to have
19 entitled -- as well, but it's strictly for an
20 arrest, for an adult arrest there.
21 And the other thing was that regarding
22 the previous motions made by CMAC and SEMSICO
23 that support all critical care paramedic
24 level agencies having to have control
25 substances by May of this year.

1 Proceedings
2 DR. MURPHY: Of 2015.
3 MR. LA MARCA: The department learned
4 that they cannot mandate that or they cannot
5 go out and enforce it right now. Legal is
6 working on it, but right now because it would
7 require someone to get a license for the
8 controlled substance, they couldn't enforce
9 it. However, in the vote of solidarity CMAC
10 pretty much said they were not backing down
11 that they do want to have this met by the end
12 of May. And that they advocated the REMAC
13 just to stand fast on that and any agency
14 does not possess those that they should
15 probably consider they are not truly an ALS
16 provider. So, those were the main things.
17 DR. MURPHY: The rational behind that
18 was if, you know, you have an agency, an ALS
19 agency showing up to a scene and a kid
20 seizing, you want them to have been benzos to
21 be able to stop the seizure. It only makes
22 sense. You have an agency role up to a, you
23 know, multi trauma and the person's, you
24 know, leg is hanging off you want them to be
25 able to have something to give them for pain.

1 Proceedings
2 So, that was the premise behind it, that this
3 should be the standard of care and why CMAC
4 was standing fast on it. I know that there
5 has been some road blocks put up and such,
6 but it really is -- really it was only one
7 area. We realized --
8 MR. LA MARCA: Long Island obviously is
9 dragging. Because many of the places upstate
10 did find ways to do it. And Long Island,
11 Nassau or whatever, Suffolk, I forgot, is
12 still fighting it. But again, Dr. Daily's
13 point was that if you don't do it you are not
14 providing the standard of care.
15 DR. MURPHY: Yeah. That was the basic
16 thing to try to make it more, you know,
17 common sense of what would you think of. You
18 know, a paramedic ambulance rides up and
19 can't give you the medicine you need and your
20 kid is seizing right there in front of them.
21 MR. LA MARCA: Some of those areas, the
22 quote unquote, paramedic unit goes out
23 doesn't have the narcotics, calls another
24 paramedic unit in to back them up that has it
25 to give it, obviously there is a delay,

1 Proceedings
2 that's number one. And number two you're
3 wasting resources, you're tying up two units
4 that could be doing other emergencies.
5 DR. MURPHY: Which the first unit should
6 be able to take care of. And I'm not sure
7 why they're recalcitrant to doing it. I mean
8 you have to apply for the application and
9 stuff, but still I don't know.
10 MR. LA MARCA: It's not too much
11 different than everything else.
12 DR. MURPHY: I know. It's just getting
13 the paper work in and having somebody do it
14 for you.
15 MR. LA MARCA: A little closer to
16 Connecticut we might push them over.
17 DR. MURPHY: Via ferry.
18 MR. HUGHES: Two other things that have
19 come down. The CMAC has also created a
20 hemorrhage control tag that's going to be
21 looking at some new hemorrhage control to
22 evaluate what's existing and packing wounds
23 and other devices that might be available.
24 The second thing that actually passed, which
25 is an article 30 change, that allows school

1 Proceedings
2 nurses to have unprescribed Epi-pens
3 available in the school, so they have to
4 register through the regional office for that
5 same as day camps and stuff like that. But
6 you will see that coming down the line where
7 there will be school nurses giving Epi-pen if
8 there is an allergic reaction.
9 DR. MURPHY: Under the hemorrhage tag
10 committee, I brought forward all of the
11 information and gave it to them about the IT
12 clamp and trauma surgeons hate them, they do
13 they absolutely hate them. What did they
14 call it? I have to think of the word. They
15 think it's a terrible --
16 DR. ARSHAD: Air clip with teeth.
17 DR. MURPHY: Say it again.
18 DR. ARSHAD: Air clip with teeth.
19 DR. MURPHY: I was like okay.
20 MR. LA MARCA: Regarding that though,
21 the wound packing, we do use, you know, the
22 products today. Are we outside of our scope
23 if we were involved in packing the wound?
24 DR. MURPHY: No. Because that's basic
25 first aid, putting pressure on a wound.

1 Proceedings
2 DR. STUTT: It's hemorrhage control.
3 DR. MURPHY: But it's the same
4 principal. It's just like holding a wound.
5 MR. LA MARCA: There was so much issue
6 made on that, I thought I was missing
7 something. I thought it was on a skill level
8 of the --
9 DR. MURPHY: No. That goes back to the
10 basic stuff. Just like putting pressure on
11 packing a wound is the same principal
12 behind --
13 DR. STUTT: My understanding that the IT
14 clamp when we did discuss it, it was just
15 another hemorrhage control device and was
16 acceptable. Without specific naming that
17 device. We said airway devices, we don't
18 specify which airway device. And it was --
19 does anybody have that recollection of that
20 meeting?
21 DR. LARSEN: I do. I have.
22 DR. BENNEK: I'm not sure what the
23 objection was on the part of the surgeon.
24 Did they have a specific reason for disliking
25 it?

1 Proceedings
2 DR. MURPHY: Yeah. What was the name of
3 the gentleman from Westchester?
4 DR. BENNEK: Dr. Marini.
5 DR. MURPHY: It could be.
6 They have a real problem at trauma
7 center with it. They don't like the IT
8 clamps at all. They don't think it should be
9 on a wound. They think it destroys the wound
10 edges. Doesn't really help. And doesn't
11 really clamp the hemorrhage. They think that
12 you have this sense of security that this
13 thing has brought wound edges together and
14 it's really not beneficial. It would be much
15 better just to pack a wound or use a clotting
16 device on top, a powder or one of the other
17 TXA or one of the other agents they feel is
18 much more efficacious.
19 DR. BENNEK: The incidents of based on
20 my experience, I think the incidents of
21 wounds that truly would need that kind of
22 device versus the amount that probably get
23 used would probably be a fair discrepancy.
24 Meaning there would be a lot of them floating
25 out there, potentially sticking people with

1 Proceedings
2 maybe only a few people who may have ever
3 seen a benefit from it. So, that's my
4 particular concern. Is it may have
5 benefitted in a limited situation whereas you
6 can get the same similar results with
7 packing.
8 DR. MURPHY: Any other comments?
9 DR. STUTT: Regarding New York State
10 Policy 1401, if anybody doesn't have a copy
11 of that, that's regarding the medical
12 direction control, that was sent -- Bill sent
13 that out in an e-mail of February 25, just
14 last week. So you should be able to find it
15 in your files that way if you don't have
16 copies here.
17 MR. HUGHES: It's also available on the
18 New York State Bureau of EMS site under
19 policies and procedures, and if you still
20 can't find it give me a call we will send it
21 out to you.
22 DR. MURPHY: Okay.
23 DR. ARSHAD: And then I would like to
24 add a couple of quick things under new
25 business if you have time.

1 Proceedings
2 DR. MURPHY: Go ahead.
3 DR. ARSHAD: So, topics that we have
4 been discussing in the Dutchess County TAG
5 meetings regarding our educational agenda for
6 the next six months. So, a little bit of a
7 scope of practice conversation, but we talked
8 about EMS leading the evidence based charge
9 in pre-hospital care. Certainly there are a
10 lot of things that we're doing that are more
11 evidence based on the emergency departments.
12 And we recognize that as a great tremendous
13 benefit of our community. So, simple things
14 that are within the scope of practice.
15 Again, teaching new dogma that's now evidence
16 based that can provide dramatic changes in
17 patient outcomes.
18 So, high flow nasal canula for our peri
19 intubation or intubation patients. So our
20 common practice has been if someone needed
21 DVM supported ventilation or if you put on a
22 hundred percent non rebreather, we now have
23 great evidence that show for your sickest
24 patients who are profoundly hypoxic, in
25 addition to putting a face mask on a

1 Proceedings
2 non-rebreather at 15 liters per minute, with
3 a separate oxygen source put on a nasal
4 canula, bump that up to 15 liters per
5 minutes.
6 (Speaker cannot be heard.)
7 DR. ARSHAD: Absolutely.
8 So, essentially, think about it this
9 way, you're going to intubate a patient who
10 is remarkably sick and ill, and now all of a
11 sudden you take away that mask or you take
12 away that BPM, how much oxygen is that
13 critically ill patient getting? A big fat
14 zero. Let's say you take a look, you need to
15 suction, not quite sure if I see the cords.
16 How much oxygen is that patient getting? Big
17 fat zero. Right. Maybe I intubate the
18 esophagus, now I need more time. Now I get
19 my tracheal intubation. So, we have now
20 multiple papers in the pre hospital and
21 critical care literature that high flow nasal
22 canula from a separate oxygen source is a
23 remarkable adjunct that reduces peri
24 intubation complication, reduces peri
25 intubation hypoxia, and symptomatic

1 Proceedings
2 bradycardia. So that's something that's
3 within both BLS and as well as the ALS scope
4 of practice that we need to start emphasizing
5 educationally as medical directors.
6 The second thing --
7 SPEAKER: Before you leave that topic,
8 just it is a part of the collaboratives for
9 medication facilitated intubation --
10 DR. MURPHY: Yeah. We put it in there.
11 SPEAKER: -- and it says consider high
12 flow nasal oxygen during intubation.
13 DR. MURPHY: We put it in there.
14 DR. ARSHAD: Let's just put it out.
15 Make sure we spread the word.
16 DR. MURPHY: I said it to my guys in the
17 department. They said, oh, it takes two
18 seconds to intubate. I said it's still
19 something you should do. Because everyone
20 always rips it off, I'm like no, keep the
21 nasal canula there, keep doing your thing,
22 let's keep going. Even with -- when we do a
23 procedure on people in the department,
24 another place that even though you have
25 everything sitting right there I crank it up

1 Proceedings
2 while they're asleep.
3 DR. ARSHAD: Definitely why give your
4 patient a stress test?
5 DR. BENNEK: Why wait for hypoxia?
6 (Speaker cannot be heard.)
7 DR. MURPHY: We get the new pads, the
8 real long extended nasal canula. The little
9 nice pads, have you seen those? They extend
10 up further so you can deliver 10, 15 liters
11 and people don't even realize this new high
12 flow delivery is so good.
13 DR. ARSHAD: Those are cool because you
14 can humidify the oxygen and you can turn your
15 flow rate up to 20 or 30 which intrinsically
16 provides PEEP.
17 So, second point along that -- second
18 point along that spectrum and this is
19 something that we have less buy in pre
20 hospitally, and this is something called a
21 PEEP valve, P-E-E-P, valve. In New Jersey
22 State we're fond of calling BBMs the bag of
23 death. It is unethical to oxygenate your
24 patient only during half the respiratory
25 cycle. I have the sickest patients, their

1 Proceedings
2 respiratory rate is zero and may be in
3 cardiac arrest certainly less than four. I'm
4 bagging, when I depress the bag they the get
5 oxygen, when I let go of the bag there is no
6 objection. I press the bag there is oxygen,
7 when I let go of the bag there is no oxygen.
8 So, the sickest patients are only getting
9 oxygenated during half of the respiratory
10 cycle. It's ludicrous. Simple five dollar
11 PEEP valve, you throw it on your BVM it keeps
12 positive and execratory pressure just like
13 when we throw them onto a vent we will have
14 intrinsic PEEPs. And now they are getting
15 oxygenated during a hundred percent of the
16 respiratory cycle. Simple five dollar valve.
17 If we can promote buying within our agencies
18 I think it's something that dramatically
19 improves outcomes, it's minimal, it doesn't
20 really bother folks.
21 And I had medics who were breaking apart
22 or ripping apart CPAP circuits, taking the
23 PEEP out from that and then applying it here.
24 So, five dollars as opposed to a hundred
25 dollars, if we can a have a broad role out

1 Proceedings
2 and certainly as medical directors emphasize
3 the educational concepts of the PEEP valve,
4 avoid the bag of death, oxygenate your
5 patients a hundred percent of the time
6 especially the sickest.
7 DR. MURPHY: Any comments?
8 SPEAKER: So, then how do we bring this
9 forward so that the region adopts or
10 encourages the education of these topics?
11 DR. MURPHY: Well, I'm going to fire off
12 to the collaborative committee -- after every
13 meeting I always fire off things that they
14 need to know. So, these will be two of them
15 added on there. The high flow nasal canula
16 we already had put in during intubation,
17 medically assisted intubation. But you know,
18 I think that it should be there for really so
19 many other avenues even on the BLS side to be
20 honest with you. But I always send it up so
21 that we all, you know, add it into that
22 conversation. And what happens is everybody
23 comments on it and e-mails fire back and
24 forth, because there could be other places
25 doing it. The PEEP valve I haven't put in

2 there, but I will make sure we add it in.
3 When to go forward, what we can do is
4 the next meeting, can you shoot everybody or
5 shoot us one thing of literature on it and we
6 will get it out to everybody.
7 DR. ARSHAD: Yeah. I am all about the
8 literature. I actually have an evidence
9 based EMS blog I will talk to you about
10 later.
11 DR. MURPHY: That way we just have one
12 thing that people can read. Because that's
13 what everybody wants to do. Once you
14 introduce something new I think it's only
15 fair that people get to read, see what'S
16 happened, where has it been used, what'S the
17 evidence behind it and then we can move
18 forward with it and add it in.
19 You know, I would imagine that there is
20 going to be other people that want to do the
21 exact same thing, so it probably will be
22 added to the agenda of the collaborative.
23 SPEAKER: How much PEEP are you talking
24 about?
25 DR. ARSHAD: It just puts in five of

2 PEEP.

3 DR. STUTT: So you can just do it as an

4 airway device, wide open.

5 DR. MURPHY: Yeah.

6 DR. STUTT: Doesn't have to be approved

7 in voting?

8 DR. MURPHY: No.

9 DR. ARSHAD: I think it's within our

10 scope of practice.

11 SPEAKER: Pam, one other thing if we

12 have an open here.

13 DR. MURPHY: Sure.

14 SPEAKER: The DOH put out part 800

15 changes. Again, if you remember we did this

16 in the past. And there was a comment period

17 where we had a small amount of time to look

18 at these things. The State did receive a

19 bunch of comments and made some changes.

20 There are about 35 pages of changes that are

21 there for part 800. There is a revised

22 period now up until the middle of March. And

23 so I had sent those on to the region, maybe

24 they can distribute them out if they wanted

25 to make comments or send anything back to the

1 Proceedings
2 State, that's open until March 13.
3 DR. MURPHY: So, we have to move on that
4 quickly. Did he send it to you?
5 MR. HUGHES: Yup.
6 DR. MURPHY: Send it out so everybody
7 can look at it.
8 MR. HUGHES: A large part of that is
9 based on the people with background checks.
10 DR. MURPHY: All important. Erik?
11 DR. LARSEN: Also under new business I
12 was wondering what people's experience has
13 been with using Toradol. I'm getting some
14 feedback from my ER docs on a few. And you
15 know, someone had chest pain so they gave
16 them Toradol and then they had a dissection.
17 So, now, you know, I don't know what the
18 evidence shows but, you know, intuitively you
19 think it's probably not a good idea, but we
20 don't know.
21 DR. ARSHAD: I think there are -- I had
22 a conversation with one of my medics
23 regarding this two overnights ago. And there
24 is a national shortage of Toradol in the
25 emergency departments. So, in fact, we have

2 more Toradol on the EMS trucks than we do in
3 the EDs. But it's a tough drug to use pre
4 hospital, because they're, in fact, so many
5 contraindications. It's probably easier not
6 to. You get into more trouble using it pre
7 hospital. There are a lot of
8 contraindications. You just have limited
9 amount of information. You certainly don't
10 know the patient based on creatinine --
11 DR. MURPHY: That's where it's hard to
12 use it without that background information
13 which we can look up in a jiffy. And my
14 utilization is very narrow, colic, that's
15 pretty much it.
16 DR. BENNEK: Personally I use Toradol a
17 fair amount. I can say my practice has
18 changed with a lack of it. But I think like
19 every other medication out there, there is no
20 magic medication that does everything. It's
21 like IV Tylenol, it's a great medication
22 until the manufacturer discovered it's a
23 medication and tripled the price.
24 DR. ARSHAD: That also recently
25 happened, we should note, for intranasal

1 Proceedings
2 Narcan. The stock price in a single day went
3 from 58 to 85, which was very good for me.
4 DR. BENNEK: Actually on my last shift,
5 one of the EMS guys said what's going on
6 here, they jacked up the price. Now that
7 everybody wants to use it they are going to
8 -- they are fleecing us. And he asked in a
9 context and I really didn't have a
10 conversation beyond that, but he asked in the
11 context is there anything that we can do to
12 address that, because it seems he silly to
13 have something that used to costs 40 some odd
14 dollars and now it's practically twice that.
15 I don't know the exact number.
16 DR. ARSHAD: I can discuss with you off
17 the record.
18 SPEAKER: Pam, is there any discussion
19 about BLS providers being able to draw off
20 Narcan from a vial and then administering it
21 using the mucosae atomizer? I know at some
22 point in the past there wasn't because there
23 were syringes and things involved and they
24 couldn't do that. And one of the ways of
25 combatting the price of this stuff going up

1 Proceedings
2 so high.
3 SPEAKER 2: Same issue with Epi.
4 DR. LARSEN: Exactly. I was just going
5 to bring that up.
6 SPEAKER: Seattle has gone from the
7 Epi-pen to the BLS folks drawing it up and
8 they cut their cost way down.
9 DR. ARSHAD: So, just so people know the
10 numbers it's six dollars versus 300 doing it
11 that way.
12 DR. LARSEN: Right. There is actually
13 somebody is going to put a proposal on the
14 Westchester REMAC this next meeting about
15 that issue. And change their practice and
16 all of the papers and stuff.
17 SPEAKER: So maybe for the
18 collaboratives then as well.
19 DR. LARSEN: I mean this is definitely
20 the kind of thing that would benefit --
21 that's the whole point of being a
22 collaborative protocol, so that everyone can
23 work together and get more action.
24 MR. HUGHES: That would be
25 intramuscular? They would do an injection on

1 Proceedings
2 it?
3 SPEAKER: For which thing?
4 MR. HUGHES: For the Epi.
5 SPEAKER: Yeah.
6 DR. LARSEN: They would just draw up a
7 little syringe and draw it up from a multi
8 dose bottle.
9 MR. LA MARCA: I think that's a
10 regulatory issue scope of practice and the
11 BLS. I think that's why it doesn't go
12 through right now. I think they make
13 regulatory change to allow them to draw them,
14 to draw up. First of all to draw up any
15 medicine, even if the Narcan wasn't in there,
16 might face the same fate. But also the
17 administration of a medication they're not
18 right now -- their scope there is no
19 injection. So, it has been discussed. I
20 think it has been brought up at CMAC because
21 of -- somebody did a study on how much it was
22 costing for the Epi-pens, because some of
23 them would obviously be expired, never used,
24 and they'd have two on a line, and pediatric
25 ones and it was an astronomical amount

1 Proceedings
2 really.
3 SPEAKER: It's killing a lot of
4 volunteer agencies.
5 DR. MURPHY: Is it in their BLS
6 education though drawing up with a needle?
7 MR. LA MARCA: No.
8 DR. MURPHY: I didn't think so.
9 MR. LA MARCA: You will have to watch,
10 with certain text books will have an
11 addendum, it will have things like that in
12 it, because certain states, it is within
13 their scope of practice and the text books is
14 so nationwide, but not in New York State.
15 That's why even when you get to like the
16 superlative airways and stuff like that, it's
17 a little wiggle room there but certainly is a
18 pilot, but it's an injectable.
19 DR. BENNEK: So, to clarify, is it the
20 issue of drawing it up or is it the issue of
21 the injectable?
22 MR. LA MARCA: Both really.
23 DR. BENNEK: So, even using an
24 atomizer --
25 MR. LA MARCA: Yeah. They shouldn't be

2 in possession of the med. They shouldn't be
3 in possession of the needles and the act of
4 drawing it up. And certainly aren't covered.
5 DR. BENNEK: I'm thinking about the
6 Narcan and using the atomizer. Because that
7 might be a way --
8 MR. LA MARCA: Once you get into an
9 atomizer that's fine but it's drawing it up.
10 DR. BENNEK: That's an issue.
11 MR. LA MARCA: Yeah.
12 DR. MURPHY: That's going to be an
13 issue.
14 MR. HUGHES: On the Narcan, if it's a
15 New York State BLS service, we do have some
16 here that we can give them. But it's a BLS
17 or FR or fire department or police department
18 that we can issue it to.
19 DR. MURPHY: But it's still tragic that
20 this thing gets, you know, rocketed up in
21 price just because now we're going to try to
22 put it everywhere and use it everywhere, it's
23 just so bad.
24 DR. STUTT: There is a work around. For
25 those BLS agencies that are connected to ALS

1 Proceedings
2 agencies, BLS units that are going out, why
3 couldn't the ALS unit put together a BLS kit?
4 Why couldn't the ALS component, in other
5 words --
6 DR. BENNEK: I was thinking the same
7 thing.
8 (Speakers speaking at once.)
9 DR. STUTT: Make your own syringes in
10 office.
11 MR. LA MARCA: Who is going to give it?
12 DR. STUTT: Sorry?
13 MR. LA MARCA: Who is going to
14 administer it?
15 DR. STUTT: The BLS person. They're
16 allowed to give Epi-pen, they're allowed to
17 give naso naloxo --
18 DR. ARSHAD: There is a difference
19 between auto injector and actively injecting.
20 MR. LA MARCA: Yeah.
21 DR. ARSHAD: It's -- regulatorily it's
22 --
23 DR. MURPHY: The only way it would work
24 is if you fill the syringes and you put the
25 atomizer on for them, but you couldn't leave

1 Proceedings
2 the needle on because they can't inject but
3 they can atomize.
4 MR. LA MARCA: First of all, you got
5 purity issues, you got expiration issues, you
6 got who you turn it over to. It's not a
7 workable solution really. That's dangerous.
8 Quite honestly, we hand it over to someone
9 and it's like who are you going to say drew
10 it up and who was packaging it.
11 DR. STUTT: Well that could all be
12 documented. And it is no different than
13 having a naso naloxo auto injector.
14 MR. LA MARCA: I don't know any agency
15 that would do it. We take all of the risks
16 on ourselves.
17 DR. STUTT: I was just throwing it out
18 there. Is that a way to work around the
19 limitation, cost limitations.
20 MR. LA MARCA: I still think with the
21 Epi-pens it is no, because you are still
22 going to have them inject.
23 SPEAKER: Epi wouldn't work that way.
24 But maybe if the hospital pharmacy was in
25 agreement with an agency that way they

1 Proceedings
2 provided it specifically that could work with
3 the Narcan.
4 DR. STUTT: It has to be the patient's
5 own.
6 SPEAKER: Right. But it's still Epi
7 auto injector that's --
8 MR. LA MARCA: What would you have for
9 an expiration on it, would you put them into
10 stock --
11 SPEAKER: I'm saying it's whatever the
12 pharmacy decides it is.
13 DR. MURPHY: Well, I still think it's
14 horrible that the drug companies are doing
15 it. That's the bottom line.
16 MR. LARSEN: You know it's going to
17 happen. They did it with the Tylenol. You
18 know, now I don't know -- there was some
19 lurch about the Tylenol stuff. They said
20 what we need to do is give 2000 milligrams of
21 Tylenol instead orally and we will probably
22 get the same affect as the injectable. But
23 they haven't done that up until now, so.
24 DR. MURPHY: All right. Any other new
25 business?

1 Proceedings
2 SPEAKER: Just for everybody's
3 information the protocol committee at least
4 discussed looking at the recertification
5 process and we will be examining some
6 additional options to possibly include some
7 skill based procedures and less attendance at
8 continuing medical education lectures. So,
9 we are going to look at that as we move
10 forward here in the future. So, if anybody
11 has some suggestions to make sure you get
12 them into the protocol committee.
13 DR. MURPHY: Yes. We are re-looking at
14 the CME education process again. We change
15 this thing like it's colors of the rainbow
16 all of the time.
17 SPEAKER: We're at the front of --
18 (Speakers speaking over each other.)
19 MR. LA MARCA: We're going with evidence
20 based experience.
21 DR. MURPHY: It's really -- it's tongue
22 and cheek what I'm saying, but it's really --
23 we want to make it so it's easier for people
24 to get their CMEs. We want you to get the
25 education and not make it so laborious that

people are running at the end of the session trying to get all of their CMEs done. And we hope that we can process through and make it a procedure that people will want to do and, you know, keep up with their stuff and not be crunch time. We all have to do CMEs, every provider. So, we just want to make it an easier process, that's why we are re looking at it again.

DR. ARSHAD: So, just a small insight that we developed in the Dutchess County meetings. Linda, who is our EMS coordinator for the county, has developed a specific website for EMS curriculum within the county itself that is publically available. And we're also coordinating all of our social media accounts with the local fire chiefs and myself and Arlington, La Grange to help advertise and just get the word out. It's a grass roots education movement and it seems to be effective.

DR. MURPHY: Excellent.

SPEAKER: Off of what Andy had talked about earlier, is the region going to be

1 Proceedings
2 promoting towards BLS CPAP as well?
3 DR. MURPHY: Yes. Absolutely. We had
4 already voted on that.
5 MR. HUGHES: We can do it.
6 DR. MURPHY: It's a thing where you just
7 have to apply for it just like the programs
8 in the past of Epi-pen and such. And Bill
9 has all of the stuff, all of the papers and
10 it's all set up. People just have to make
11 the application process.
12 SPEAKER: Okay.
13 MR. HUGHES: At this point in time it
14 has not been signed by the director of health
15 for New York State. We're waiting for that
16 to come down. Once it comes down then it's
17 available.
18 MR. LA MARCA: The results of the pilot
19 were accepted.
20 DR. MURPHY: Yeah. And everything was
21 moved forward and everybody voted on it.
22 MR. LA MARCA: It was a very small
23 sample for some reason that came through but
24 it was a --
25 (Speaker cannot be heard.)

1 Proceedings
2 DR. MURPHY: Anything else?
3 Thank you everybody. I will ask for a
4 motion to adjourn.
5 DR. ARSHAD: Second.
6 DR. MURPHY: All right. Thanks
7 everyone.
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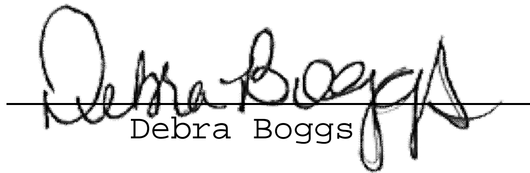
8 

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