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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, September 21, 2015, at 9:30 a.m.

Yvette Arnold,

Court Reporter

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MIKE BENENATI
ISRAEL KNOBLOCH
DAVE VIOLANTE
ANDY LAMARCA
MIKE MURPHY
NELSON MACHADO
RICHARD PARRISH

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DR. MURPHY: Good morning. Let's bring the meeting to order. Thank you all for coming.

It seems like it's been forever since we were here. I guess this summer seemed longer to me this year, I don't know why. But in lieu of that, thank you all for kind of putting up with us to change the date last week. We didn't realize it coincided with the holiday. So thanks for showing up.

We do not have a quorum yet, but hopefully one or two more people will come and then we will be able to vote on some issues today that I would like to get passed through. One being -- we already discussed -- but we will see how it goes from here and hopefully some more people will show up.

To start I would like to review the minutes from last meeting. If anybody has any questions, additions, deletions, just let us know. The last meeting was June 1st, we can't vote on the minutes yet, but we can table that until we see who else shows up.

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Anybody have any corrections, additions, or deletions? Please just let me know and you can forward them through.

Under old business, a couple of things we had talked about in June at the last meeting, the collaborative protocol had put through a couple of corrections they've asked us to review. And we actually voted on this the last meeting, but we can't go on that vote because we didn't put it up for public comment. It was basically increasing the midazolam fills in the excited delirium protocol. The reason being, all of the reactions and cases they were having at some of these concerts with the synthetic cannabinoids. And what they felt that they really needed to have the preferred route be ten milligrams IM and that's increasing the dose from five milligrams, they felt that the additional sedation was desperately needed. We sent out an advisory about this, you should have all received the advisory back in August, but because we had not put it to a public comment period we couldn't officially

take that vote -- but we did vote on this the last time. And we had zero comment so we put these things out for comments and nothing came back. So maybe if nobody shows up we can still keep that because we voted on it in June.

Secondly, in your packets you should see this entity called the 2011 Guidelines For Field Triage of Injured Patients what the -- one of the agency -- one of the regions north had put these through for us to review so they are here for you to review and to look at. We would like to also include these in an update to the guideline because what we have there is out of date and the changes are highlighted -- but probably only on mine. Are they --

MS. DELAUNAY: They are --

DR. MURPHY: You are awesome. Can I just tell you how much Karen does for this office above and beyond the call of duty -- turn the camera -- turn the camera.

So these are small changes, but they definitely make a difference in terms of the

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Glascow Coma scale and chest fall stability and some things about low impact and rapid deceleration injuries. So they are on there and this is something that, again, we could vote on if everybody felt comfortable. But --

Good, Dr. Arshad, one more. Good job.

So we will revisit that, but it is something that we should have -- you know, we neglected to pull it forward. It's really a fault of the collaborative committee. One gentleman realized hey, guys, we are using the really old guideline so we want to include that in our new roll out and revision.

So those are the two things under our collaborative protocols.

Anybody from protocol committee have anything you want to talk about?

We have to revise the exam, I am faulty on that. I have to get a hold of Sal to do that --

MR. LAMARCA: I think we agreed, you know, we have to redo the exam. I think

the --

DR. MURPHY: Yeah. We have to make it a little bit more straightforward. I actually now have a personal experience. One of my scribes at work, who I think is very smart, failed the exam by one point. It's like, what? And I, you know, told her, make sure you prepare, you read everything and go through the administrative manual, you are responsible for all this stuff. She got a 74 and passing is 75. She missed it. I'm like, this is a smart girl. So that reinforced that even more that we have to make sure we show up prepared. Most people walk into NOVO (phonetic) and fail miserably. So we'll have to review that and that's my thing to do with Sal. And I promise before the next meeting we will have that done and get it to protocol committee, that's definitely important.

MR. HUGHES: I just have an issue or question that has come up. We have some people in the northern area that are looking to hire some critical care and some MDLTs, which we don't have a MAC test. I know that

when we bring them into the region they have to have a two-tiered system. So we are going to continue with that and so we have to create tests for that and get them certified to operate in our area.

DR. MURPHY: And do you -- you want to answer that?

MR. LAMARCA: No -- again, years ago the REMAC did advise we can use critical care with a paramedic, again, that operationally doesn't really save many people anything because half the time we use the critical care technician in lieu of the paramedic. So I guess you could say we already have in our operational guidelines we could use them in that sort of system.

I guess the question is if those companies are going to agree to that because if we find them running without a paramedic there is an issue --

DR. MURPHY: Right. That was the major thing we saw before, most people are not using the designation anymore, that was the issue I had. We are trying to get away from

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that designation so I guess we'll have to revisit it if really someone is going to go through with it. However, they have to really come forward and make sure, like Andy said, it has the proper personnel involved.

MR. LAMARCA: Additionally --

MR. VIOLANTE: There are no other training courses in the area that provide --

DR. MURPHY: Right. I thought it was a dead issue to be honest with you until you guys sent me that e-mail. I'm like, what?

MR. HUGHES: This particular situation is the person is already an EMT out of another region wants to ride in this organization that is an ALS organization.

MR. LAMARCA: I think one of the other problems was looking back when the State Council did sort of an audit of programs, we found that those level programs did anything from literally a hundred some odd hours to some of them ran shortly underneath the paramedic level program. No idea what sort of course most come from because we had no experience here in the region of running them

anymore.

DR. PAPISH: Is it just for one guy?

MR. HUGHES: At this point in time it's only one person and one agency --

(Everyone is speaking at once.)

DR. PAPISH: It's easier to send him to an upgrade course.

DR. MURPHY: Yeah. I think -- I couldn't believe it when it came across. I was like, really? Somebody still had this? I thought it was interesting. Okay?

DR. ARSHAD: Dr. Murphy, a quick question, we have some hospital colleagues here and they brought it to my attention that September is sepsis awareness month --

DR. MURPHY: My favorite thing --

DR. ARSHAD: Absolutely --

DR. MURPHY: Go ahead -- sorry.

DR. ARSHAD: And the recognition of prehospital sepsis has been something that obviously we have been studying for a long period of time. Several recent papers have come out either meta analysis --

(Everyone is speaking at once.)

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DR. ARSHAD: -- review papers that have come out recently regarding best practices, recognition of prehospital sepsis, and even some very interesting pieces interfacing with nursing homes and things along those lines. I'm wondering if it's okay if we review some of the sepsis protocols and add these references in to tie in some of the best practices. And the neat stuff about this literature is outcome --

DR. MURPHY: I think anything you feel is warranted sitting on this committee you can bring forward to the collaborative committee. You met Mike Dailey, he sent me an --

DR. ARSHAD: He is absolutely lovely and extended his warm --

DR. MURPHY: Yeah. Well, I told him also, why doesn't he send you an invite to the next collaborative meeting? Because I feel like it's his thing. But, you know, I do tell him, hey, why don't you invite -- so I think you are going to get an invite to come see. The problem is that we haven't had

a SEMAC meeting. We were supposed to have one in September, we didn't, and we are not having one until December. So it does put a big hole there of information and relay of information and kind of forwarding things up and things, you know, cascading down. So it definitely is a very valuable tool and that is something we can bring to collaborative committee because people out there might already have started stuff, so we can all work together to put it together. Just like the spinal immobilization thing, it was like perfect timing, everybody came together, the State came together and it all kind of worked. So absolutely it's a possibility. And if you want to put together something -- and, you know, I haven't heard back from him, but I'm sure he is going to send you an invite. You could present it that day. What we do is every time there is a SEMAC meeting we meet during the middle of the break, in the afternoon, evening, or both, and it's an open meeting, it's not closed to anyone. It's just you have to hike up to the meeting

just outside of Albany.

DR. ARSHAD: Sure.

DR. MURPHY: So that was a nice segue to spinal immobilization. As you know, the State revised all the spinal immobilization and the whole entire process of teaching. All the BLS agencies are to have had their update and their training -- by the end of this month, right?

MR. HUGHES: October.

MR. VIOLANTE: October 31st.

DR. MURPHY: October 31st? Halloween. So they have to have it done by that. There is a nice little area on Department of Health website, which is an FAQ to go through all the information and everything, any kind of technical problems, or any kind of questions and such.

And, also, thank you to Dr. Arshad for bringing forth our protocol and our preliminary work on it and everybody on the protocol committee coming together. It worked out well and was done quite briskly compared to in the past.

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MR. HUGHES: With some of the BLS services from our REMSCO meeting, we heard that they are not aware that this has to be done. I'm not exactly sure why, but if you do see people or if you are a medical director for any of these services, please let them know it needs to be done by October 1st -- 31st. They had been notified by both the county coordinators, by the State, by us, the paperwork is out there and we worked with them as much as we can. We do have -- if they can't have access to their computers or something like that we do have it on a thumb drive that we can give them, just about everything except the test. So we will work with them. If you hear agencies or somebody is not aware, have them get in touch with us and we will walk them through.

DR. MURPHY: Yeah, that's kind of impossible that they could not have known about it in my humble opinion.

MR. HUGHES: There were quite a few at the REMSCO meeting that were not aware or said their agencies were not aware of it.

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DR. MURPHY: Okay. Well, we will continue to strive and bring that information forward.

Okay, CPAP for BLS. Has anybody applied?

MR. HUGHES: We have two agencies that have applied that are working through it and they have --

DR. MURPHY: Okay. So everything is on the website, all the application process, all the information and the -- so it's two so far?

MR. HUGHES: Yes.

DR. MURPHY: Who are they? Can we know?

MR. HUGHES: I don't know off the top of my head.

DR. MURPHY: I was just curious. So that's another, you know, advent that the State had brought forward to allow the BLS agencies to participate. Everyone should take a look at their protocol, it is a BLS protocol, and just make sure you are familiar with it. It's coming our way.

Any comment, questions? Or I'll move

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on --

MR. LAMARCA: Not really comment, but at the other meetings we have discussed all the different things the BLS services can do and they have a very spotty, you know, number of them that accept certain things. So what we talked about is actually to get something out about some of the frequently asked questions about all the different elements that, you know, BLS service will apply for permission to -- because really across the board those that actually use breathing treatments, anything, that's been a voluntary submission, they are really abysmal performance wise.

DR. MURPHY: A lot of them -- I don't know how many are doing it -- I hear more and more from people like BLS approaching because they want to do it so I don't know if in this area --

MR. LAMARCA: We just don't think they are focused, they don't know procedure. Because we are looking at the use of the Narcan and they are surrounded by fire and police agencies that are doing it and they

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are not, so getting the whole packet out, these are the things you can do.

DR. MURPHY: I think also getting medical directors more involved with them, notoriously in the area people have been like a name on a piece of paper, but really no real input into the agency. So you might be approached, physicians around the table, as BLS agencies wanting to do this. They need to have a physician director on board, medical director to do these increased expanded care issues. So it's all good, but we need to make sure we are utilizing what we have out there.

DR. ARSHAD: Along those lines, I think Sharon and I did a CME on BLS level CPAP probably a couple months, I'm happy to share that lecture with anybody that wants it.

DR. MURPHY: That's great. Again, I think all that stuff is good. What we can do is take a look at it and disseminate it with the FAQ so that people can see it. I think that sometimes people are just set in what they have been doing and change is always a

scary thing for some people. So we definitely need to advance our practice level at all levels.

Speaking of that, service upgrades -- oh, I was trying to move on -- go ahead.

MR. BENENATI: And I don't want to discuss this today, but maybe something for future consideration -- it seems that there is a gap with communicating with BLS agencies and that gap is only getting bigger. And maybe we need to be looking at what that root cause is because it's only going to continue to snowball so --

DR. MURPHY: They are supposed to have more input into the REMSCO. I mean that's really -- that's probably we are even further gap away because REMSCO is really their forum. However, I still think it's a big void --

MR. BENENATI: It is --

DR. MURPHY: And I think we still need to improve on that every single time. I think first would be to start with, we would see who they have as their medical director

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too. I think that's a place to start. And make sure we get the communication out there and that people realize how important it is and it's not just, you know, your name on the piece of paper anymore, there really are some issues that affect the BLS community.

David?

MR. VIOLANTE: Yeah, I think this is a good time to follow-up. When the protocols first came out and we had this discussion about BLS agencies now falling under the REMAC and under REMSCO and that component, it was significantly different than it had been and a bunch of docs went out and talked to different counties and that was great. And maybe we need to follow-up with that again in some way, shape, or form to bring everybody in -- not specifically you.

DR. MURPHY: I know because I think I did them all --

(Everyone is speaking at once.)

DR. MURPHY: It's okay, it was fun. It was actually good because it got me out there to see what people are doing too and meet

faces of people that I've not met so, you know, it's okay. And I thought it was really well-received and we had good attendance.

MR. PARRISH: There is a communications issue that was brought up. And at the county level, the county councils aren't doing their job with BLS. We talk about it. What can we do with BLS? We don't have much regulatory authority over them --

DR. MURPHY: We have none actually.

MR. PARRISH: We can do something with ALS, but BLS, the impression is a lot of BLS organizations are, I'm out here doing my own thing. They are not part of the system and we have to find a way to pull them into the system.

DR. MURPHY: I think you are correct, Rich, but I think that the one way if they want to do something different, if they want to advance themselves, if they want to learn more and I think that's how we took the approach with this last go around, was not to be punitive, but more to say, guys, this is what is happening. We want to be more

involved, we want to have more education out there, we want to have more opportunities for you and we want people to be involved sort of from the advent. And I think it was well-received, I think we definitely had more people come forward and be involved. However, Rich, you are exactly correct. I mean, it's a system that has to be, you know, able to be disseminated. So the county coordinators and the county REMSCOs are extremely important in terms of following up with everyone and kind of integrating the network, which definitely can be fragmented.

So we have to continue to keep working at it. But I think when we first came up with the collaborative protocols a few years ago it was like oooh -- we really didn't have the BLS contingency implied here. So now it's all good, it is all moving in the right direction, but we still have a long ways to go, Rich, I agree.

MR. PARRISH: They are still not involved. We said, yeah with the BLS collaborative protocols, but take a look back

at -- we were talking about the spinal immobilization and I see it all the time and I'm sure the others, there is a lot of agencies, when did that come out? And, you know, I blasted out -- I'm sure everybody else blasted out -- but they are in their own little world out there and they have no desire to advance.

DR. MURPHY: Well, they have to get the information from the State so I'm sure that they have heard it. Do they put it to the wayside and not pay attention maybe? But I think either it's going to be through peer pressure, through when they bring patients in, through educational processes, through us continuing to get the word out there and to keep people going. We are just going to have to keep -- you know, how do you eat an elephant? One bite at a time. We are going to have to keep taking bites and try our best.

But I agree with you, Rich. You have been doing this a long time and see a lot of stuff so we will continue to try and keep

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changing, keep moving.

All right, any comment or concerns?

Service upgrade. We have in the room today a follow-up to Town of Wallkill. I thank you guys all for coming.

MS. BARBEE: Teri, T-E-R-I, Barbee, B-A-R-B-E-E. And I actually have a narrative portion I'll hand to you.

At 0000 hours on February 15, 2015, TOWVAC became an advanced life support provider and simultaneously went live with new EPCR. Since then TOWVAC has had at least one ALS ambulance in service operating out of our station at 22 Maltese Drive, Middletown, New York 10940, 24 hours a day. We also staff an additional unit during the day as volume requires and staffing allows. Our staffing has remained fairly consistent since the upgrade, although we continuously seek to recruit quality personnel.

TOWVAC carries all ALS equipment and medications required by the Hudson Valley REMSCO. We are currently using Lifepak 12 cardiac monitors, we are capable of data

transmission to receiving facilities via the Lifenet system. We carry the EZ10 gun with multiple size needles for use on adult and pediatric patients without IV access. We currently carry one three channel Alaris medication infusion pump on board and have an LTV 1200 ventilator available at our station. All staff members are in-serviced on all equipment during their orientation and field training. Paramedics are trained to be able to recognize the indications for and operate the equipment in accordance with state and regional protocols. EMTs and drivers are trained to assist paramedics to the extent that their scope of practice allows.

Although our primary response area is over 62 square miles, TOWVAC has an average response time of 6 minutes 45 seconds. TOWVAC -- sorry -- TOWVAC has been dispatched to 1,818 calls since February 15th, we are currently on pace to surpass last year's call volume by over 150 calls. TOWVAC has responded to 89 percent of these calls. Twenty-three have been mutual aid requests to

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Goshen, Montgomery, Pine Bush, Mamakating and Mobile Live Support Services. TOWVAC has a 100 percent response rate for all first calls. Standbys are never covered by the first due ambulance and responses are only turned over to mutual aid if TOWVAC units are already assigned to a call. 87 percent of our calls result in patient contact, the remainder includes standbys and cancelled or unfounded calls. TOWVAC'S average total call time is 45 minutes.

Due to an oversight by the ESO implementation staff, PCRs were not initially being transmitted to the New York State Bridge. This was noted in early March when we logged onto the New York State Bridge to research validation trends. The situation was reported to Mr. Jeffery Crutcher, the QA/QI Coordinator, at the Hudson Valley REMSCO and the problem was rectified by ESO administration. All EPCRs have been appropriately submitted since that time, including the records that predated the issue. It was also brought to TOWVAC's

attention that due to the stripped nature of the EPCRs sent to the New York State Bridge, electronic advanced airway placement verification forms were not being transmitted with the associated EPCRs. This issue was addressed with Mr. Crutcher as well. Multiple attempts were made to fax the completed forms to the REMSCO for their records, but due to technical difficulties, it was arranged to have the documents sent via e-mail directly to Mr. Crutcher. At this time all records have been forwarded to the REMSCO, including the records that predated the issue.

All patient care reports are reviewed for completeness, accuracy and appropriateness of treatment by the QA/QI officer. Patient care reports are then selected, based on state, regional and agency policy, to be further reviewed by TOWVAC's QA/QI committee. The committee, which includes TOWVAC's medical director, meets monthly. The committee works to improve the overall quality of care and documentation

through reinforcement and remediation of staff based on clinical best practice. Through this process, the committee has identified and worked to improve on a number of trends such as:

A documentation trend was noted in which providers were not adequately documenting the duration and description of witnessed seizures. Providers were educated in the importance of thorough documentation, which needed to include these details as well as last known seizure event, changes in medication, habits, and other associated signs and symptoms which would help improve the quality of the patient's continued care at the receiving facility.

A documentation trend was noted in which providers were not adequately documenting the information presented to patients regarding their refusal of medical care and transport. Providers were educated in the importance of thorough documentation that included details regarding the possible risks/repercussions of refusal explained to the patient as well as

the continued availability of the 9-1-1 system and details regarding patient's mental status and ability to understand same.

In an effort to enhance early detection and treatment of life threatening conditions, although no specific trend has been detected, the committee has worked to ensure that all patients receive a thorough assessment, including the cardiac assessment of patients with atypical presentations and/or associated risk factors such as elderly, cardiac history and vague symptoms.

With regard to our future plans, TOWVAC is currently in the process of expanding our services. We have hired a transport coordinator and begun taking emergency as well as nonemergent transfers to and from local facilities. We are awaiting delivery of a new ambulance and are equipping all of our units with automatic vehicle locators.

As an agency, TOWVAC intends to continue to grow and become a model for others to follow. Professionally, our staff are held to higher than industry standards. Our

response times are well below the national average and we constantly push to improve them. Since our upgrade, every unit in service has a paramedic on board who is to make first contact with all patients. Our staff are charged with the responsibility to treat every patient they come into contact with as if they were treating their own family members. Our goal is to provide patients with the best possible care in the prehospital environment to ensure the best possible outcome. In the years ahead we will continue to strive for excellence in all that we do.

DR. MURPHY: Thank you. Dr. Roantree, the medical director, is also here if anybody has any questions, concerns, issues.

Rosie, if you have anything you want to add?

DR. ROANTREE: No. I think the level of care our providers give to the community is excellent, it's far above even what I've experienced in the past and the type of paramedic I was for 10 years probably. They

are probably a lot better than I am. But they are going to continue to give that excellent level of care, I expect that from them and the whole committee we meet with every month expects that from them as well.

DR. MURPHY: Okay, thank you. Thanks for bringing the report and statistics forward. So we are supposed to also move on that, but we don't have a quorum either.

MR. HUGHES: It's a six month review, really the annual review is where you move --

DR. MURPHY: But it's a thing -- well, this will go into the minutes and be here. Thank you.

DR. VOHRA: How short are you?

DR. MURPHY: I think one -- two. It has to be eight unfortunately.

Thank you, guys, and thanks for all the effort from TOWVAC and from Dr. Roantree.

So Dr. Berkowitz couldn't be here. I don't know, Mark, if you wanted to speak about any of these things, or you want me to just bring them up?

DR. PAPISH: You can just bring them up,

you are doing great.

DR. MURPHY: Okay, so they are out on the table out there for people to grab. He asked us to forward through a few documents to distribute.

One is, the Hudson Valley RTAC had met and developed a field triage criteria and you can see on there -- it's the colorful handout -- for certain traumas and things in the field to occur -- when they occur, what would be the next course of action and how to triage these patients appropriately. People can review that and look at it, it's really for dissemination at this point. So one -- and it's attached to -- there is a multi-level triage criteria guideline so that when patients go to the nearest facility with the time frame and the triage criteria to get them to a level one trauma center, or a level two trauma center depending on the type of patient.

So those are FYI for right now. We would like people to look at them. We can discuss it at another time just so you can

feel comfortable reviewing everything.

But what we would like to put out today in addition to what Dr. Berkowitz gave us, there is a letter from myself, from the RTAC and from Eric from the Westchester REMAC, is a letter to support the protocol to allow blood products to be used in interfacility transports until the blood product protocol officially comes down from the State. It's somewhere on someone's desk being ready to be signed, I've been told, and that it's formulated and it's final form. It has not come through yet so the RTAC had asked that we put a letter from myself and from Westchester region to help the State allow us to still allow blood transportation in interfacility transports. As of now it is not something that is specifically done and it's supposed to be addressed in the new protocols.

MR. LAMARCA: Lee Burns had said it is done and it's to be possibly posted to the register this month and that --

DR. MURPHY: Okay, great. So then it

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has to have been signed. I know she had -- so the whole thing was finished, it was just literally having to be signed off. So we can -- I can still put this through. You can tell Dr. Berkowitz we can put it through. But that's a good update, thanks, Andy, long overdue. It will be great to have the blood product protocol out there for everyone.

Evaluation subcommittee. We had no issues to report on at this time.

Stuhlmiller, he is not here?

MR. HUGHES: No, but he sent us a note saying he had no report.

DR. MURPHY: So Dr. Stuhlmiller had no report. He gave a great lecture yesterday for -- the Orange Regional put out a trauma nursing ED conference yesterday and David was fantastic. And Rosie -- Dr. Roantree spoke too, it was great.

Helicopter committee report then we will table right now since there is no report.

Quality improvement project. So Jeff had put forth that for the New Year of 2000 -- end of 2015 into 2016, that we do a

cardiac arrest study. The last one that has been done in the region was in the early 2000s, 2003 specifically. And we would like to be able to include this as our new QI project for the year forward. Since that study, you know, many things have changed, pad sites are definitely more prevalent, mechanical devices are out there, we have been using a lot of IOs and different things. So what we would like to do is put the word out that we'd like to incorporate and capture all of the PCRs for cardiac arrest and that will be the new QI project for this year, that would be what we would like to study. It's something that I think helps that we make sure that, you know, we are doing the CPR, we are getting the defibrillations in there, we are getting the patient's arrival to the emergency department in a timely fashion and this would be something we'd like to review. So that's going to be our project for this year going forward.

Any comment?

Under new business, a couple of things.

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Because we can't act upon it, the midazolam increase we have to figure out, we did vote last time before the procedure followed, but we will see what is happening with that.

Under new things, we received a letter from Vassar Brothers that Dr. Brooks will not be the representative from Vassar and it will be Dr. Arshad from here on, with Gary as backup.

We also received a note from Lee Burns that the provisional level three trauma designation for ORMC has expired. They are continually working towards successful verification, but in the interim they are not a level three at this time. And that's a notice from the State Department of Health.

We have two advisories we put out since the last meeting. There has been a tremendous shortage of epinephrine, just like all these other drugs coming through. So we put out an advisory of how we can make epinephrine from the different concentrations and with warnings and references -- Westchester did exactly the same and we kind

of mirrored it. And, hopefully, this will become a moot point eventually, but one of the things that is important is that we try to have some kind of standard of care and advisory out there for everyone. So that is what that was all about.

And I think the next thing that is going to come up will be the Narcan because it's becoming so expensive for the little injectors that -- of course because of supply and demand I'm sure -- we are going to have to work on that. I know Dr. Dailey has worked on a project of trying to figure out another way we can get them done in a cheaper fashion and to go from there.

MR. VIOLANTE: That's for the epinephrine?

DR. MURPHY: Yeah -- and also the availability of Narcan, I should say -- yeah. Yeah, he made a little kit actually.

There are no system upgrades for this month. We do have a bunch of notifications.

Please be advised James Catalono out of Troy, New York has suspended for one year,

effective September 4th of this year. The suspension is stayed, but he is placed on three years probation and assessed a civil penalty.

Hempstead Fire Department Rescue Squad Number 1 out of Hempstead, New York, suspended for one year. The suspension is stayed, that was effective July 23rd, assessed a civil penalty.

Heather Jinda of Collins, New York had her certification revoked as of July 23rd for violations of Part 800.

Richard Schwartz out of Amherst, New York, was suspended for three years. The suspension is stayed and he is placed under probation for three years, effective July 23rd.

Jeffery Brown out of Fulton, New York has assessed a civil penalty of $2,000.00 and -- for violations of Part 800. His suspension violated Part 800, within three years he will automatically be revoked if he don't follow through on what the penalties were. So as of right now he is trying to

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move forward to not lose his certification.

Lancaster Volunteer Ambulance Corps out of Lancaster, New York was assessed a civil penalty of $2,000.00, the entity is stayed and placed on probation as of July 23rd.

So those are the actions from the Department of Health this month.

That leads me to open forum. Anybody want to bring things forward?

DR. ARSHAD: Two educational initiatives that I just wanted to announce and invite everyone to participate in.

A couple of things going forward, we know at the NREMT level there has been a move towards adopting simulation as a part of training curriculum and sort of more formally allowing folks that are running EMS paramedic programs to incorporate and allow simulation in testing and scenario design. So in partnership with Laerdal we are going to be doing monthly CMEs at their simulation center. And hopefully in combination with these two gentleman here, we are also going to design a longitudinal curriculum on crew

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CPR, which I suspect will tie in nicely with the QA project on cardiac arrest.

Typically we have anywhere from 50 to 75 providers that show up. So please, I need other physicians and health care professionals to help with the initiative. It's typically our structure is one hour lecture and one hour small group simulation. And they have eight to ten mannequins, we design small case scenarios to test specific skills. It's really exciting, we need the team --

DR. MURPHY: Over in Wappingers?

DR. ARSHAD: Wappingers, yes, it's awesome.

Second initiative -- it's my passion, I'm very excited -- is EMS pod cast. So when we talk about emergency medicine and critical care training in the past two to three years has changed dramatically. And we have more and more evidence based studies coming out on the value of pod casts, blogs, social media, and developing educational initiatives and just helping folks digest information.

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Everybody is busy, it's automatically downloaded to your smart phone, it makes knowledge acquisition so easy. A number of excellent EM pod casts out there now, but no real high quality EMS pod casts. So we are launching one in about a week. I can't tell you the name yet, but the design is such that day one is going to be an interview with an Eagle and we are going to sort of explore the history of EMS, the challenges they faced in the system. How did you accomplish X, Y, Z? And rehash the history. The first is with Dr. Paul Pepe, it is ALS level simulation. So we are going to bring simulation to everyone's smart phone, we know folks can't afford hundred thousand dollar mannequins. But we will design at the ALS level and Wednesday is going to be our weekly wrap up of journal club, which we live tweet. The first episode is the New England Journal has airway article how the --

(The speaker cannot be heard.)

DR. ARSHAD: -- Thursday is BLS level simulation and Friday is going to be wellness

topic.

And we are just returning from EMS world expo -- and I'm saying this with love -- but it was very interesting, there were two convention EMS expos, as well as Mr. Olympia. Seeing the two sort of groups intermingle, it was very interesting. They were talking about focused on health, nutrition, body morphology, et cetera. We want to help build a community that is nonjudgmental and supportive --

(The speaker cannot be heard.)

DR ARSHAD: -- hygiene, circadian rhythms, wellness, exercise, et cetera, et cetera. We hope to be the launch of the longitudinal project free sort of help without inequality or disparities in level of care that we see.

DR. MURPHY: In that wellness should also be their safety too, is that primary thing of, you know, we had in the last few years, had a couple of tragic events prehospital with our providers so that should tie in. But absolutely, I think personal

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health is amazingly important.

DR. ARSHAD: We had a pod cast scheduled on EMS provider safety. I love how the social media things take root, it shares a project called Code Green Project on prehospital care suicide, depression and the stigma of discussing these things and finding support. So that's going to be in wellness as well.

DR. MURPHY: Very good. If people want to help you with the simulation labs and training, the curriculum, Laerdal project, they should contact you directly?

MR. BENENATI: Yes. Contact him directly via Twitter or any other means, yes --

DR. ARSHAD: Yes --

(The speaker cannot be heard.)

DR. MURPHY: Okay, that was good.

Any other comments, concerns?

Any new business you want to bring up?

Anything?

Okay, if not, I'll have a motion to adjourn.

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DR. VOHRA: Motion --

DR. MURPHY: And second?

DR. PAPISH: Second.

DR. MURPHY: Thank you, everyone.

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

Yvette Arnold