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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, November 2, 2015, at 9:30 a.m.

Yvette Arnold,

Court Reporter

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DR. MARK PAPISH,
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DR. KWON,
Physician Representative

PUTNAM HOSPITAL CENTER

DR. FRANCINE BROOKS,
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ST. ANTHONY COMMUNITY HOSPITAL

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MID HUDSON REGIONAL HOSPITAL OF WMC

DR. MARK PAPISH,
Director

DR. BERKOWITZ,
Physician Representative

VASSAR BROTHERS MEDICAL CENTER

DR. ARSHAD,
Physician Representative

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

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

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DR. MURPHY: We will bring the meeting to order, everyone. Good morning. Thank you everybody for coming.

This morning I just want to say too bad for the Mets, but -- no -- seriously, they were underdogs. I don't really care about any baseball team but --

DR. BROOKS: They have won --

DR. MURPHY: -- so this morning I just want to ask that we could have an acceptance of the minutes. They were sent out electronically, hopefully everybody got to look at them. And please bring forward any revisions, corrections, deletions, or additions? And otherwise if they are accepted as is I put out a motion to accept the minutes now.

DR. MAO: Motion to accept the minutes.

DR. MURPHY: And a second?

DR. BERKOWITZ: Second.

DR. MURPHY: Thank you very much.

So in terms of old business, the collaborative committee, Joseph Bart -- Joe Bart out of the Northern Region made a really

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nice video for instructional purposes for spinal immobilization. So if people need to have a program to put out to continue on teaching everybody about the new protocol, you can let me know. And I can give you -- he loaded it up on YouTube, I can give you the site. I was going to print it out for everybody on my electronic thing so if anybody wants one, please come to me. No negative comment, but it's better than the ones I've seen before. So if anybody wants to use it, please let me know. He is putting it out there for anyone, so you don't have to reinvent the wheel, or do anything. It's a nice little succinct program.

Secondly, from before we had talked about in the protocols increasing the first line dose of midazolam from five milligrams to ten milligrams when it comes to excited delirium and in certain situations. And the reason why it came up is from this summer and some of the lovely concerts the younger generations go to and that they really found that they needed a higher dose of midazolam.

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So we had talked about it and we had discussed and moved it forward, but we didn't have a quorum the last time. So I wanted to bring it forward to have an official vote. Has everybody read that little kind of -- it was just a collaboration, a suggestion to move the dosage up? And any concerns, or any questions, or can we move ahead with a vote?

Did you guys read it, do you remember?

It's been so long, it's two motions ago --

(Everyone is speaking at once.)

DR. BERKOWITZ: Have you reviewed is the use of Versed in the region? Have you looked at the cases? Is it being used appropriately and re you happy with it for excited delirium --

DR. MURPHY: Yeah. I have not had anything come to mind from my cases. I have not had any cases to review for excited delirium in the field, certainly in the ER quite a bit. But, you know, I don't know if any other medical directors can say --

DR. WILSON: It's proposed that the

first initial dose is 10 regardless of weight --

DR. MURPHY: Yeah -- well, I think it's still a clinical decision, but they wanted to be able to give them that plausible number because at these little events -- and it would be under the special entity of, you know, a real true excited delirium in an adult, of course. But they were just running into trouble with managing the cases and so that's what they were asking for. And it was due to, you know, the stuff up in Bethel, the stuff over in Saugerties, the events that occurred.

MR. BENENATI: And the colabs have approved it, we are one of the last regions that has not approved it at this point as well.

DR. MURPHY: Correct. We had talked about it, but have to --

DR. ARSHAD: The language, up to -- is 10 the initial dose, or up to 10 milligrams?

DR. MURPHY: Up to 10 milligrams. Yeah, up to, just so they had that leeway --

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DR. ARSHAD: Also just a talking point, I know in neighboring counties they have ketamine ion their local formularies.

DR. MURPHY: Yeah, that's in the new -- the protocols that are going to be put forth soon at the beginning of the year, or towards the end of this year, that's included, ketamine is added. It's something that has been a very controversial subject for the State, not for us, per se. And SEMAC brought it up many many times so, you know, we are still taking baby steps here, but moving forward. But that's absolutely on there.

DR. PAPISH: There was a study that came out -- wasn't there a study 40 percent intubation rate of those patients post arrival --

DR. ARSHAD: Which patients --

DR. BERKOWITZ: -- ketamine that was the study out of California, I think, Oakland --

DR. MURPHY: They had a high --

(Everyone is speaking at once.)

DR. STUHLMILLER: The training hospitals --

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DR. PAPISH: -- that's just in -- you don't know they are from academic centers so it's a little bias there.

DR. BERKOWITZ: This is a good teaching case.

DR. PAPISH: I just mean they would be more aggressive to proceed actively, manage the airway --

DR. MURPHY: Maybe the ketamine wasn't effective enough --

(Everyone is speaking at once.)

DR. MURPHY: -- I'm just kidding.

DR. BERKOWITZ: It was the patient was just way too --

DR. MURPHY: Snowed.

DR. BERKOWITZ: Yeah.

DR. MURPHY: I read the blip, but I didn't read the full --

DR. PAPISH: That being said, I don't know whether it's one study and I don't know whether it's really something --

DR. ARSHAD: I think there is a good prehospital literature and it's primarily out of Miami and it's described as super excited

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delirium where they have a certain demographic local population that is prone to high doses of both cocaine and alcohol --

(The speaker cannot be heard.)

DR. ARSHAD: -- kilogram intramuscularly and if they still had agitation within three to five minutes later they followed up with a subsequent dose of benzodiazepine so their overall intubation rate was less than two percent.

DR. PAPISH: The patients getting five milligrams per kilogram or greater were the ones primarily getting intubated.

DR. ARSHAD: Dose matters.

DR. PAPISH: It does -- what is the other dose?

DR. MURPHY: I think they are talking the one, one to two.

DR. BERKOWITZ: That might be --

DR. PAPISH: That's fine.

DR. WILSON: For the sake of this discussion we are mostly talking about Versed as far as approval?

DR. MURPHY: Yeah.

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DR. WILSON: The only thing I would like to comment for the record is the ketamine when it does come up, I know not having a rescue -- giving IM ketamine without a rescue IV can be a recipe for disaster because of the laryngospasm that can happen.

DR. MURPHY: I'll add that comment to the committee -- you know, I have not seen the final product to say this is what it said. But I'll add that --

SPEAKER: -- the ketamine, if they give it you can get an IV and slip it in quick.

DR. WILSON: Not at our hospital, that's the problem --

(The speaker cannot be heard.)

DR. WILSON: -- one out of a thousand will have a laryngospasm where you wish you could relax them with something other than IM medication, that's just my two cents -- my one cent.

DR. KWON: I'm Dr. Kwon representing Nyack Hospital for Dr. Shah.

DR. PAPISH: We were wording our exit delirium protocol at the hospital, it's not

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published yet, but as the indication is actually a conscious sedation procedure using ketamine for the purpose of putting somebody in restraints that you otherwise can't get in restraints because they are so --

DR. STUHLMILLER: In our national protocols is for sedation 0.5 to 1 milligrams per kilogram with a repeat dose in 10 minutes if ineffective. And we also have other options, midazolam, or lorazepam, diazepam, or -- as well as options to use as a sedative.

DR. PAPISH: So to what you were saying, the protocol as proposed dose is a max of 10, but they are going to be starting at five --

DR. MURPHY: Yeah, up to -- just so we can give them some leeway in certain clinical pictures. It was not, you know, the gunshot. But especially after these attendees and these events that occurred, this is where that came out of.

MR. BENENATI: Just a point of clarification, we are viewing the current protocol that we are currently operating

under, ketamine is in the protocol today. It's three to five milligrams per kilo IM paramedic order only and it's not a required medication. So that's why I don't think a lot of people are familiar with it, it's not a --

DR. MURPHY: Exactly, that's what I meant. But that -- but it's going to become part of the protocol as standing going forward with the new ones, but right now no, we don't even have it so.

MR. BENENATI: But it's optional?

DR. MURPHY: It's optional --

DR. BERKOWITZ: Physician optional.

MR. BENENATI: -- based on the agency really.

DR. MURPHY: I don't think we have had anybody put it in yet, not in our region.

DR. BERKOWITZ: I know in Westchester it hasn't been used, but we reviewed the cases -- several cases that used it with Versed so.

DR. ARSHAD: I think the largest data said in -- on the planet is from Hennepin County, Minnesota. Actually they are leaders

in ketamine for excited delirium. They presented a 2008 case, it was of prehospital delivered intramuscular ketamine and their intubation was less than 1.4 percent, something along those lines.

DR. MURPHY: Yeah, I think that, you know, they want to make it more incorporated into the system so that's what they are looking at right now, but I don't have that preliminary info. But, again, it's to push it forward so that people can use it and have it if it's available.

DR. PAPISH: So you need a motion?

DR. MURPHY: Yeah. Yes. So I'll make a motion that we accept the new revision to the collaborative protocols for excited delirium that the initial dose of midazolam can increase from five milligrams up to ten milligrams.

All those in favor?

So it's unanimous. Thank you.

I'll come back to the collaborative protocols update under new business because there is some stuff -- we had a conference

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call and I'll bring that up in a little bit.

But I'll stay in the order we have the agenda in.

So RTAC, Dr. Berkowitz?

DR. BERKOWITZ: So a couple of things came up. I think, first of all -- I don't know if there is a quorum here -- I can present this again, this came out of RTAC --

DR. MURPHY: There is a quorum.

DR. BERKOWITZ: Was there a quorum last time?

DR. MURPHY: No.

DR. BERKOWITZ: I don't know if we need to vote on it, but this is the decision guidelines that came out of the RTAC the last time around. I can pass it around. This one is basically using the CDC field guidelines. And then this was straight from the RTAC with a couple of -- including pediatrics and specific criteria for TVI that based on our evidence the RTAC agreed we'd be better off having -- going right to a high level trauma center.

So we can pass these along.

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The other thing that came up, there was a long discussion of immobilization. A couple of things that came out of that, first of all, I think that -- you know, I've noticed clinically that there has been a fair amount of patients that have been coming in with C spine immobilization without backboard, which is fine, but are sitting up, sitting upright. You know, anywhere from 30 to 45, even more, depending on the mechanism, including a patient who was actually quadriplegic from an accident and was siting upright. Which probably isn't -- I wanted to see what people here think about that. Should we be keeping the patients in spinal motion restriction, but without a backboard, or should we just let them sit up?

DR. STUHLMILLER: I said at the RTAC they should maintain spinal motion restriction during transport so --

DR. BERKOWITZ: Okay. What do you think, should we not use the backboard, but lay the patient flat? And if there is any disagreement with that?

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MR. PARRISH: The guidelines on the spinal immobilization is that you can sit them in a not -- at a 90, but at a 45 degree angle.

MR. BENENATI: The literature wasn't completely clear. It was -- the slides and the -- you know, the exam and what was said were conflicting. So it was not clear at all --

SPEAKER: If you look at Bart's video it makes it much clearer.

DR. BERKOWITZ: What is Bart's video?

SPEAKER: The one that Pam said before --

DR. MURPHY: Yeah, I'll give you the website.

SPEAKER: -- he has two twenty minute presentations each and one is frequently asked questions and the second is live demonstrations from risk. And, you know, so he went over everything and the dos, the don'ts and will someone get castrated if they bring somebody in on the board and that kind of stuff. So it led to a lot of information

to what maybe wasn't presented in the WebX.

DR. BERKOWITZ: In that video what does he say about --

SPEAKER: Basically they can be sitting up, you know, the 45 degree angle position of comfort based on the Nexus studies.

DR. BERKOWITZ: If they are based on the Nexus study --

(Everyone is speaking at once.)

SPEAKER: -- he referenced Nexus and the reasons behind why this is happening and he basically said you don't have to bring them in on the board, they don't have to be always lying flat.

DR. BERKOWITZ: The Nexus criteria means you have to have a normal neurological exam. If you have patients who have neurological, altered mental status, or distracting injuries I think maybe they should have spinal motion restriction.

DR. MURPHY: Yeah, I think the way it's setup is the clinical decision has to be made that if you think you really need spinal immobilization, you leave them flat. They

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don't have to be on a board, but they can still be -- spinal immobilization restriction is the proper term --

DR. BERKOWITZ: Exactly.

DR. MURPHY: But, again, it goes down to clinical mechanism of what they --

MR. MURPHY: Can I ask a clarification? Spinal motion restriction is only considered if the patient is flat? If the patient is at a 45 degree angle then you are not using spinal motion restriction? That's contrary to everything that's being distributed out --

DR. BERKOWITZ: That's why I'm raising the question, because I think there is confusion on what should be happening in these scenarios where patients are unable to be cleared and they are -- you know, should be transported flat or transported sitting upright. Clearly it sounds like the education has been upright --

DR. PAPISH: Does anybody know the medical evidence? I honestly don't know. Arshad, I'll point to you.

DR. ARSHAD: Yeah, there are so many

articles that have come out in terms of is the supine position the ideal position for maintaining cervical spine immobilization. And there are three recent studies out of Europe that have actually patients who are vomiting, yet have altered sensorium, as trauma patients in the left lateral decubitus position with --

(The speaker cannot be heard.)

DR. ARSHAD: -- it was primarily retrospective data. There was a very low incidence of cervical spine fractures, which we know is the same with our trauma cohort, and there were no additional injuries noted or neurological sequela by patients in the left lateral decubitus position.

So do we have good evidence out there? Not really. Can you probably raise a patient up 15, 20, 35, 40 degrees? I don't see a reason why not, you have the collar in place. And what if they are vomiting?

DR. BERKOWITZ: Sure. There is always a situation where if they are vomiting, you know, if they are going to aspirate they are

going to die from aspiration, that's obviously a bigger concern.

DR. ARSHAD: I think the question with spinal immobile is that the more comfortable the patient is the better the immobilization. In other words, we thought backboards was a good idea, but they were so uncomfortable that, in fact, they were moving around more. Same thing with cervical spine immobilization. We have the splint, it's more physiologic as opposed to the long backboard, but if they are just more comfortable at a slight incline I think it's probably going to be protective.

DR. MURPHY: Andy?

MR. LAMARCA: Lacking a REMAC advisory to the contrary you are going to whatever the State put out, it's go to be --

DR. BERKOWITZ: Sure. Sure.

MR. LAMARCA: -- so you have to raise to the level indicating this is a concern to REMAC and have an advisory, otherwise it goes the way it is now.

DR. BERKOWITZ: I'll take it back to the

RTAC and let them say what they think it should be. Should patients be coming in slightly up or not? And as well as take a look at the literature, but it's definitely happening.

DR. PAPISH: I think it's prudent to say if someone has a neurologic deficit it would seem intuitive to keep them flat, if someone has a fracture of lumbar spine --

(Everyone is speaking at once.)

DR. BERKOWITZ: That was kind of where I kind of started to say this seems to be maybe the question of whether the pendulum has swung where a patient is essentially quadriplegic --

MR. LAMARCA: In the face of neurological deficit at the scene they are going to put on a backboard --

DR. MURPHY: And they are allowed to, that's the way they are -- that's where the problem came from. All of the immobilization data or concerns was from the trauma surgeons who said, what do you mean you are going to take away the backboard? Our guys went

ballistic just recently at a case that came in and I don't think they had any real mechanism of spinal trauma. And he was so taken aback that there was no backboard and I think the trauma surgeons are still out there saying, you know, they are still uncomfortable removing backboards.

DR. BERKOWITZ: Our trauma surgeons don't have an issue with the lack of backboard. I think we have seen enough bed sores, honestly, from long transport to never want to see a backboard again. I think that the question I just have is, you know --

DR. MURPHY: Positions of that --

DR. BERKOWITZ: -- positions, when should we be positioning flat and when --

DR. MURPHY: And I'm not sure there is data because it's so new. Do we have enough spinal restriction versus putting them in 30 degrees, 40 degrees, or -- you know, I can't imagine having them sitting bolt upright though like Mark just said. If there really is neurological deficit I would think they be using some device to immobilize the

lower spine or restrict the lower spine movement.

DR. BERKOWITZ: I think we need to look at that. So we discussed the -- our institutional protocol for receiving interfacility patients is that we never assume -- we never take another institutions C spine as being official. Which from the trauma center perspective and all the trauma surgeons say, of course, kind of as you'd expect. They are all saying, of course, why would you expect I'm not taking someone else's clearance as my own. And when patients come to the institution if they don't have a collar and the mechanism warranted a collar they get a collar put back even if they are cleared. Which has lead to some elements of conflict or disagreement about why we are doing this and what we are doing this.

So the first thing that I did is resent out an advisory explaining why this happens and why EMS certainly should take their orders from the sending physician. If the

orders say C spine is cleared, that means the C spine is cleared and that's the right thing to do. And that our institutional right thing is to the follow the processes because that's how you don't have missed injuries.

After the RTAC there was discussion whether they wanted to make a recommendation to that for all interfacilities that cervical immobilization be made -- be maintained until the ultimate destination receives the patient. I don't think we voted -- do we vote on that? We did vote on that, right?

DR. STUHLMILLER: We voted yes, we would like to recommend all hospitals if you are sending a patient to trauma center leave them in or put them back in cervical collar for transport.

DR. BERKOWITZ: Basically to avoid that scenario. I think that the RTAC was going to release some guidelines, or what is used to clear in the hospital C spine. But, you know, I think that that was -- yeah, I guess I didn't get the language and asked them to send the language and I never got it. So

that was there and that's open for discussion. I wanted to see what people here think about that. I think it's a really complicated issue and I think that it -- I can see there is a lot of was of seeing it certainly. If you as a treating physician in a hospital see a patient and you think the C spine is cleared it's not really fair to you, nor the patient, to say, well, I think you don't need this device, but I'm going to leave it on you because the other guy wants it. We certainly don't want to interfere with that care that is going on there. At the same time it's important when people come to our institutions that we follow up on it. And our processes are there because we do occasionally find missed injuries. We do occasionally find, you know, either inadequately imaged, misread, there is a bunch of things found over the course of years that lead us as a trauma center to be -- to want to not to assume that the cervical spine clearance that was done was done completely. And the best way we found

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to ensure that is to assume from the get go, you know, de novo, that everything needs to be at least considered.

So I just wanted to put that out there what people think about that issue? Anyone?

MR. VIOLANTE: Is there any data on the difference of patients that come in that actually have missed injuries --

DR. BERKOWITZ: So the outcomes data in terms of whether they suffer neurologic damage, I would be highly doubtful that there would be any patients who would have suffered a neurologic injury from that. I think the likelihood of missed unstable injury is much lower than the likelihood of just a missed injury. But when you have patients who are, you know, coming to the ER and then going to the operating room for orthopedic procedure and the anesthesiologist is manipulating a fair amount and there is a lot of stuff and you find out later on that there is a missed injury seen that is stable and not an issue, it does make the whole system want to say --

(Everyone is speaking at once.)

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DR. MURPHY: At the end --

DR. BERKOWITZ: And not have those things happen.

DR. MURPHY: It makes sense what you are saying. I actually had a couple of patients we sent down there and I was like, oh, they made you put the collar back on? Because I had done a scan of the neck and cleared them. But it makes sense what you are saying. Unfortunately it's duplication --

DR. BERKOWITZ: It is a duplication --

DR. MURPHY: I don't know how to get around it though.

MR. LAMARCA: Well, when we saw your advisory, again, we were trying to figure out can I take the orders of the transferring hospital's physician? It would be helpful to try to get something in the notes who pronounced the C spine clear, and get down there and prepare for the fact Westchester will put a collar back on. We just went through the transport and now we have a collar back on.

My question is normally there is a

contact between the transferring and accepting hospital, wouldn't it be more prudent if in that discussion the order is placed to put the collar back on the patient?

DR. MURPHY: For the transport? I mean we can make it that fashion --

MR. LAMARCA: -- and, again, I just think if it's part of the transferring order from the receiving hospital to the transferring hospital it eliminates a lot of the issue, I think.

DR. BERKOWITZ: So -- and we have raised that as well -- to start having trauma surgeons recommend to continue C spine immobilization. That being said, you know, we don't -- the receiving hospital doesn't make any orders to -- the patient is the sending hospital's patient until they get to our campus. Everything that happens until that moment is, you know -- if we accept the patient we really are saying, hey, we can take care of the patient you say you can't, bring him to us. So we can make recommendations and I am encouraging our

surgeons to maybe -- take that recommendation, but it's certainly not going to happen in every case. And there are a lot of cases where the patients are either fairly ill or there is a lot going on where it's hard to kind of stick it in there for each one.

MR. LAMARCA: I understand, but it seems to be it would be clearer for everyone if there was agreement between the transferring and receiving hospital to place them on the collar for transport.

DR. HOLDEN: If we cleared somebody clinically, I understand you might be reluctant to accept that. But if the patient already had a CT, surely there is a mechanism that could develop those images so the radiologist could be looking at them while the patient is en route, so they are cleared by your radiologist but before the patient gets there.

DR. BERKOWITZ: But the clearance involves clinical evaluation, it's not just a radiologist.

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DR. HOLDEN: Right. I imagine -- I am just putting myself in the patient's shoes. If I've been seen and scanned and it's, you know, it's negative, might there be like a tiny miss rate of, you know, less than one percent? Maybe. But I agree, I think the likelihood of missing something clinically relevant in a patient who had a CT is probably pretty small. And it would be frustrating for me to say, wait a minute, you just told me my spine is okay. Why do I have to put this thing back on for an hour and a half ride down to Westchester?

DR. BERKOWITZ: And, again, I agree exactly with what you are saying about some of this. But, you know, there is no really good way of -- in the absence of an exam there is no good way of saying someone's spine is clear. That's why the advisory, the sending doctor makes the determination and we follow institutional processes.

DR. MURPHY: So when they hit the door you are going to follow their institutional process because that's --

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DR. BERKOWITZ: That's what we do. And I think that -- I think a better way or at least the way I like to think of it is that we'd be aware of this, this is how we operate and it's not about mistrust or about anything, it's about that --

DR. MURPHY: Protocol.

DR. BERKOWITZ: Protocol. And when the ACS comes and looks and verifies they look for missed injuries and, you know, buckets of charts where a patient comes in and they say C spine is not immobilization and then later on they are found to have injury, they would ding us for that. So how are we going to prevent that from happening?

MR. VIOLANTE: Is there some standard that could go out to all the hospitals that we could follow?

DR. BERKOWITZ: You know a third -- from nontrauma centers there is a fair amount of variability. I think the better way of thinking about this is when we put the collar back on it's not because we don't have -- that there is an injury, that there is an

issue, it's actually just that this is our process and usually it comes off within a half hour to an hour. But while the images are being evaluated and while everything is being done, they put the collar on. And my feeling on the matter is -- I just want everyone to be open about it so that no one feels that we are either duplicating or not trusting, that we are just following our processes. We don't want to have -- we are held to a very certain standard for the American College of Surgeons and that's really good for us. That's really forced us to become a better trauma center than without it. But one of the byproducts of that process we really really need to dot our I's and cross our T's.

DR. VANROEKENS: So, again, this is -- I don't think anyone of us have a problem with a recommendation, or even a strong recommendation. I think the issue is on case by case basis, some patients have CHS, COPD and how they are immobilized can make an issue. If we clinically cleared them we need

to let them know we might leave the collar on because we want to be absolutely certain. That's a little different from putting somebody on a backboard, which is what we were doing 10 years ago. Every patient sent to trauma center was put on backboard and left on it. I think that's overboard. I think the whole issue of how we immobilize them, you have to make sure there is not an issue. So we don't have a problem with it being a strong recommendation. I think the point that you are accepting the patient, talk doc to doc, they had major head injury, why don't we keep them in the collar until everything is clear? And we will make sure that our places are aware of that. There maybe some cases you probably won't want to do that, but it would be case by case basis and discussed.

DR. BROOKS: I think the issue also is the patient, if we explain to a patient we think you are clear, you have a CAT scan, but there is a chance you can have missed and the accepting hospital wants to make 100 percent

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sure, we may put a collar back on, this is protocol. And educate them, I think that would be fine. I think most patients and patients' families want to make sure, you know. So I think it's a matter of education. I understand, you know, that you need to be 100 percent sure and in the rush of stuff where things can happen. A CAT scan is very good. But clinically things can happen, there can be injuries with negative CAT scan. So I think it's not so bad to put a collar on and discuss with the patient, this is what is protocol for the accepting institution that is a higher level of trauma and --

DR. BERKOWITZ: I agree, but education? How about just communication? I think the worse situations happen when people haven't communicated about this.

DR. MURPHY: And I think the other thing that you can educate the patient on -- communication, we are putting you back in ambulance again and you are being transported again, just for safety, that's also an issue.

DR. KWON: Do you rescan the patients?

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DR. BERKOWITZ: No, they don't get reimaged. So the process there is, you know, all the images -- if you are on a PACS, which a lot of hospitals are, they are uploaded and then the official -- the read of the outside hospital are compared to our radiologist's evaluation and then a decision is made whether to accept the outside reading. And if there is an issue then they figure out what do to, sometimes for C spine if there is an issue or question they can get an MRI and sometimes, rarely, patients are reimaged. We have actually cut down on reimaging a lot in the past five or ten years, mostly because of region PACS and the quality of films is better in general.

DR. KWON: The other ONE is, I don't think if you have penetrating trauma, if you have penetrating trauma nowhere near the C spine, is that --

DR. BERKOWITZ: No -- yes. The C spine, it's pretty clear. Penetrating trauma -- people are very cavalier. I would almost say with penetrating trauma you first have to

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ask, did you only get shot, or did you get kicked and beat too? Because sometimes they kick you, beat you and then they shoot you. Generally isolated penetrating injuries not near the C spine don't need to be immobilized.

Mike -- sorry --

DR. MURPHY: That's okay.

MR. MURPHY: I just want to throw this out on the table. This patient education, this is obviously Westchester's protocols and we respect that. So our crews when we saw the first notice have been educating our patients on the way down, listen, when we take you into Westchester Medical Center you are considered a new patient, even though you had these tests and your spine has been cleared they are going to redo it just to be on the safe side. So they are going be applying the neck device on you in a couple hours back, you know, in the ER. I think that if we do it -- we are doing it, Mobile Life does it, all the transport EMS agencies do that in a trauma case, as far as

educational purposes then I think we are good. I don't think we need to have our patients transported for an hour plus in a cervical collar, that is uncomfortable and may not be necessary when it's a simple educational process of our crews and paramedic and EMT saying, listen, when we give -- case in point, this is bizarre. Helen Hayes Hospital in the admission process asks everyone have they ever been a coal miner. That is part of their admission process. So you can bring in a 79 year old grandmother and they will ask her straight-faced, have you ever been a coal miner? Have you ever been diagnosed with black lung disease? We educate our patients when we transport to Helen Hayes, they are going to ask you some very bizarre questions, but it's part of their process.

DR. MURPHY: Do you know Patsy Cline?

MR. MURPHY: I think we can do that with our cases that --

DR. MURPHY: Yeah, that's the standard --

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MR. MURPHY: We can educate our patients on the way down and we don't have to go through the rest of the discussion. We will take care of it.

DR. MURPHY: I think we have to get the information out there because people can misconstrue, they don't trust us, they are doubting us, they are second guessing us. But that makes perfect sense what you are describing, you have an institutional protocol you have to follow, you are going to clinically clear the C spine. That doesn't necessarily mean they are going to be reimaged --

DR. BERKOWITZ: -- rarely reimaged.

MR. MURPHY: If you wanted to write a simple patient education script for everything we'd be more than happy to disseminate that.

DR. BERKOWITZ: I can work on that, that's a great idea. I think what you are doing is really helpful and I really appreciate it.

MR. LAMARCA: Like Miranda cards --

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DR. MURPHY: With name and phone number on the back.

Anything else from RTAC, or is that it?

DR. BERKOWITZ: I think that is it.

MR. BENENATI: Did he need a vote on the adoption of those documents that you passed around? Because I think we passed over that if you were intending to have that done. In other words, how do we go about distribution and education in the field and getting those into the collaboratives?

DR. MURPHY: The collaboratives have already taken the field triage, that's already in there. That's in the new stuff they are looking at. The pie diagram, I don't know, I have to check on that. But definitely this was taken towards collaborative already. Since this more our region I would think it stays more within our region. But why doesn't everybody look at it and we will put it on the agenda and get it clarified. But it brings to the table the issues of regional stuff versus the collaborative stuff, which we'll get to. But

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we can always do regional approved issues that you want because every region is different and that's what we talked about when we joined the collaboratives.

Okay, next on the agenda is service upgrades. There is none.

Evaluation subcommittee report, Dr. Brooks?

DR. BROOKS: Nothing active.

DR. MURPHY: Helicopter committee, Dr. Stuhlmiller?

DR. STUHLMILLER: There has about no business before the committee.

DR. MURPHY: Yes, we had your report from the last meeting and that was from the last -- quality improvement, Jeff?

MR. CRUTCHER: Biggest thing we've got going here is EPCRs. Several agencies have taken the jump, including TransCare, Northern Dutchess Paramedics will be up. One of the things that has been problematic is the delivery of the hard copy to the ER. State is aware of that, the agencies have been made acutely aware of that. We have had a number

of discussions with Image Trends as far as being able to accurately get the data where it needs to go. Part of that issue is obviously going to be a cost issue in the hospital. We have been working on solutions for that. Mike Taylor from the State has been well-involved in this. There is a local vendor in Fishkill that does electronic health records and they have now entered the arena to see what they can do to put the data where it belongs. So it's an ongoing issue, no imminent signs of resolution, but it's being worked on.

The move to the Nemesis 3 Bridge, probably by the end of June next year is what we are looking at. Most of the EPCR vendors have been placing Nemesis 3 data elements into what they are doing now just to make the transition a little bit easier so agencies don't get hit with a huge upgrade all at once.

There has been an issue with Zoll as far as the data going up to the State server. They had a large group of data essentially

stuck in the queue and that has kind of slowed down the actual validation reports. It's not that it's not getting there, it's just kind of spinning until the data gets out of the queue.

And that's pretty much it.

MR. PARRISH: What is the cost issue to the hospitals?

MR. CRUTCHER: Several thousand dollars, like 18 to 20,000.

MR. PARRISH: To do what? Right now I provide a fax machine, a printer. And I'm still not getting them and this should not be additional cost --

MR. CRUTCHER: What they are looking at is actually placing the data into the patient records in a seamless manner, so that's a software cost.

MR. PARRISH: That's part of the EMR and that's down the road --

MR. CRUTCHER: Yes.

MR. PARRISH: -- there is a program to do that, but right now I'm still not getting --

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MR. CRUTCHER: And we are still working on that.

MR. PARRISH: One particular agency --

MR. CRUTCHER: And we are still working on that, yes.

MR. VIOLANTE: Jeff, is the State Bridge something that any EPCR user will be able to dump their data into and provide a report to the hospital?

MR. CRUTCHER: You already have access to it, so yes, you can.

MR. VIOLANTE: So at their point of service when they drop a patient off when they upload their EPCR for completion it will then transfer through State Bridge to the hospital?

MR. CRUTCHER: Not directly, no, and that's the interface they are working on. You can see the data and you can print the data obviously, but it's not being integrated. And that's the part of the puzzle they are still trying to work on.

MR. VIOLANTE: We have been working with ESO in Dutchess trying to get hospitals up

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with that same idea --

MR. CRUTCHER: Yep. Yep. And the positive end of that too is if we could put data in we can also get data back out, which would be a tremendous benefit to kind of closing the loop with QA/QI.

MR. VIOLANTE: Absolutely.

MR. PARRISH: Albany Med already does that --

MR. CRUTCHER: Yes, they do.

MR. PARRISH: -- a patient up to Albany Med, like Diaz takes a patient, by the time they get back they have an update on their patient.

DR. MURPHY: Yeah. I think that communication going both ways will be so helpful and make QI for everyone a lot easier and actually more productive because we will have real time numbers -- hopefully. Thanks.

So under new business, this brings us back to the collaborative protocols. Because there was no SEMAC in September we didn't have a face-to-face meeting so we had a phone conference call and quite a few issues were

brought across.

And just FYI, anybody can call into these meetings and be part of the protocol meetings. I think that there is a lot that goes on electronically so that you can have updates, you can look at what people are discussing, and what ideas people are putting out. There is no formal mechanism for ideas and additions, deletions, things to add or subtract from going forward. However, I'm going to bring it up to the committee to say, could we have a formal kind of electronic methodology for people to put stuff in? Because right now we just send back e-mails back and forth, you get the e-mails and -- you know, sometimes I don't know what happens to them afterwards so what the discussion has been and what people are working on. So the first thing that was brought up at this meeting was how to facilitate making this a more organized approach so that the information is out there and we are all on the same page and everybody knows what is happening. It's difficult because of the

size of the region and it's not an easy process. And as we all know, the last time we rolled out the protocols there was a little bit of a lag in communication and ability to get things. So we are trying to make it a more seamless process. Tim from REMO is spearheading that TAG, let's say, for lack of a better word, to look at what is the best process that we can do this so we all get the information. I think that from conversations I've had with people there is no kind of secretive society here. Anybody can go on and be part of these conversations. And if you go to SEMAC there is always a face-to-face meeting. So you guys are welcome and to put forth information we have to have a better mechanism so that it goes right in and everybody can see what the ideas are and the suggestions. So that is something that we have to facilitate.

The other thing that is a big topic of discussion is the whole process of collaborative protocols and your regional -- your REMAC, like our Hudson Valley REMAC. If

we wants things to be a little bit different or we don't want to adopt certain things how do we do that process and how does it remain all legal and such. So there is a small group headed by Dr. Cushman, who is looking at now that process, the governance and the procedural process of how we can keep this all functioning and keep it legal. And will there be some kind of memorandum of understanding legally of this is how we are going to work it. But the bottom line is, any protocol issue from the State they look at it that our REMAC is responsible. So we can be a member of collaborative protocols and a member of the institution of collaboration, but if we need to change things, if we need to advise things, if we need to do things because every region is not the same, we can do such. We just have to do it in the procedure proper and vote on it and have everybody in agreement or majority. So these are all things we are looking at because we didn't realize how big this was going to get so quickly. However, the other

caveat there is they don't want people in and out of the collaborative protocols system so we are going to look at a methodology of once you join, you join. Kind of like the military, you are in for a period of time and you do it, you don't jump in and out, in and out, in and out. And we just come to some mechanism that we can all discuss things and make it work. Because I think, you know, there is no sense of reinventing the wheel. If we work on things together, do things together, improve together it works a lot faster and a lot easier when we come as a group to the State. And that we can have many more minds thinking alike or bringing up other issues that we can all talk about it and make it the right thing.

So that's the principal they are working on. It's tactically going to still take some work, but we are going to have another face-to-face meeting in December.

MR. LAMARCA: Part of those discussions they had about credentialing --

DR. MURPHY: Oh, one of the things --

well, that was not so much as the collaborative committee cannot interfere with our credentialing process, that each region has to have their only credentialing process. I don't know if it included that. I had to -- I was at my CME so I had to hang-up on the meeting so I didn't get to finish it. But I'll ask that question because they were talking more about that the regions retain all their administrative issues. You know how we have it in a manual, our separate administrative manual, that you keep those things separate. They shouldn't be in the collaboration protocols. Those kind of organizational and way things work should remain separate because it's not part of the collaboration. But that credentialing between areas is very important and should be in there. I think that should be something we do under the MUO.

Okay. And so a couple of things people have brought up, you know, they want to put patellar reduction in there as a new procedure for ALS. One of the regions up

north is putting that through. They are going to introduce it as a physician option. New York State is not too happy about that. Just FYI -- straighten their leg.

The other, we have three working side groups, one working on diabetic emergencies, end of life termination and, again, the excited delirium chemical restraint thing is a big one. The working groups did not have anything new for me to pass along at this time, but those are the functional groups right now working forward.

But, again, if you go to SEMAC, you are at SEMAC, please get in touch with one of us, especially Dr. Dailey will decide when we are having the meeting. Is it the night after SEMAC or before? So we always have a face-to-face meeting. But we have to facilitate that communication and delivery of the information both ways, coming up and going down. So that is something that we are looking at.

Unfortunately we did not have a SEMAC in September and it's -- the next one is

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December 8th and 9th so we did not have a face-to-face in-between the last meeting.

Any questions? Any concerns?

Again, I can give anybody that wants the e-mail I can put you on the e-mail group and give you the e-mail to write in so you can get these updates, you know, periodically when things are being pushed around.

So there is also -- they are looking at some new drugs, dexamethasone versus solumedrol, adding Tylenol liquid in the field and a question of just some different medicines. You know, some of them -- Tylenol liquid, some of the medics came on and were saying, you know, quite vivaciously, like we have to measure liquid? You know, like treating fever in the field is one of the issues. Sepsis is big one coming up in terms of how do we institute sepsis protocols in the field? And that's actually being worked on by one of the physician in the group.

DR. PAPISH: They don't take temperatures --

DR. MURPHY: That's what they are

looking at is the whole thing, that would be the first step. Not a mommy temperature and no putting your lips on their forehead.

Yeah, so those are all the things that are coming up. But, again, you know, any kind of input, anything that people want, please let me know. I'll make sure you are added on and I can give you the e-mail address and the collaborative committee.

So next under new business, we received notice from the Department of Health that they were investigating an issue at BVAC and through multiple phone calls and investigations the State had to act pretty aggressively because there were some issues with their narcotic process. And in conference call with myself and Eric and the office here and with the State we had to put their ALS status on hold for a period of time to allow them to remediate -- to work with the bureau and New York State to rectify and remediate and resolve their issues. I don't have to go into too much more detail than that. If people want information I can give

it, but it was basically a very quick action we had to take at that moment to ensure patient safety is really the bottom line. And I'll give you update on that. They have remediation in process, everything is going very well. The institution is helping, they do their narcotics through one of the Hudson Valley Hospitals and it's moving forward.

Also under new business, I'm sure everybody received -- the blood product was finally put out by the State. It doesn't effect so much our prehospital care, it is mostly interfacility transports and the blood products recommendations have been put on and finally approved.

Sorry -- Andy?

MR. LAMARCA: Again, we were happy to finally see it come through, not happy to see how it came through. You know, for the most part is every service would have to go through every hospital in the system. And I was wondering if there was anyway to regionalize some of this. We talked to Lee Burns about this, it seems like every single

service -- if there is five services doing transports to eleven, twelve hospitals each has to go through the same process for the same end result, which doesn't seem to be streamlining anything in our opinion.

Is there anyway we can look at the region in some way -- for lack of a better term -- other than regionalizing this?

DR. MURPHY: I can ask them. My gut feeling is no. What do you guys think in the back there?

SPEAKER: I don't know to be honest with you.

DR. MURPHY: Yeah. It was so hard to get this part out initially, just this part. I will bring it up at the meeting though, you --

MR. LAMARCA: We'd have to have an agreement with every hospital, their blood bank and it's all for the same purpose. And some of the hospitals are scratching their heads already. So I'm not really sure -- if not -- if not I would ask that maybe the REMAC physicians help us with contacts at

their own hospitals to try and get this moving forward.

DR. MURPHY: I think a lot of people were unaware that it didn't happen to be honest. I don't think they ever thought it was an issue. I think they probably thought you always transported with blood, you know. If you think about it from a logistics point of view and patient safety and necessity that's probably why they are scratching their heads.

Also under new business, Karen put out the schedule for the REMAC meeting dates. Please look at them and review and make sure there is no problems with the dates, anything that we know in advance and we can keep the schedule and not have to at the last minute change.

Also, I received the resignation from Dr. Stutt this morning for Medical Director of the region. So that's a huge loss for us, Eric has been here for a very long time. I don't know how many years --

DR. BROOKS: Since 1990.

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DR. MURPHY: Yeah, it's got to be at least -- so you know he needs to pursue other things. He will be moving forward, but that means that the position of the Medical Director of the region will be vacant. And I'm going to make a suggestion to the REMSCO because that's who officially makes the designation and such, so I think that anyone who is interested, you know, should definitely make themselves known to the office.

When is the next REMSCO meeting, next Wednesday?

MS. DELAUNAY: December.

DR. MURPHY: The Wednesday -- second Wednesday? Third. So maybe we can put some names forward before that meeting. So if anyone is interested, as the Medical Director, you know, you are really responsible for the protocols, for what happens under the facilitation of all as it means. But Eric has been doing it a long time and I understand, I totally can see people needing to move on. But it would also

be good for the region because then we have new faces, new people.

So, Dr. Papish, I'm going to recommend your name.

DR. BERKOWITZ: I was just telling him that, I'll second that --

MR. BENENATI: You did a pretty good job of running the meeting before though.

DR. BERKOWITZ: I forgot about that.

DR. MURPHY: But, you know, just I think anyone is definitely -- if you are interested half the battle is really having a passion and interest, wanting to facilitate and improve the care and to have really some medical direction. There is times that the issue is extremely poignant and other times it's not a lot. A lot can be done electronically and a lot can be done through other formats. And, you know, the office has my phone and e-mail and they don't use it that often, really rarely. It's really an easy job. I used to do both of them for a while, but I definitely don't want to do that again. And I think it's just not good to

have it be the same person. I think you need to have two different people and you need to have people looking at things. So we want to thank Eric for all of his years of work and input, but as that being said, we will be looking for people to volunteer up their name for it.

Also, we will be kind of revamping evaluation committee too. Evaluation committee, it's really just members of the committee -- to set forth -- it has to do -- be somebody from the office, the medical director has to be there so it's really quite easy for that to move forward.

Under PAD, Epipen and Albuterol. Nothing -- oh, no -- we had one PAD site. One PAD site to move forward. Foundry, I think -- I forget the name of the Foundry here right in Rock Hill -- not Rock Hill -- Rock Tavern, New York.

MR. CRUTCHER: Tallix Foundry, T-A-L-L-I-X.

DR. MURPHY: Is an institution putting forth a PAD site, so that paperwork is being

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forwarded onto the State.

And that brings us to open forum. Anybody have anything they want to bring up this morning?

MR. BERKOWITZ: One thing I wanted to bring up to a vote to see if there would be interest in forming a TAG that would be joint between Hudson Valley and Westchester REMAC to have interfacility transport protocols. Because there is still a lot of confusion about what should happen in these transports. The issue with C spine, that happens, there is a lot of other similar issues, whether it's appropriate foods on a child or baby, or you know --

(Everyone is speaking at once.)

DR. BERKOWITZ: -- like patients getting TBA. I've had a lot of permutations of things. I think we can probably improve and help patient care. I think that it would be great to have both regions together just from manpower perspective. And so I want to see if we can vote to form a formal TAG and hopefully get some members and start divvying

up the work.

DR. MURPHY: Well, I think notoriously -- and I'll speak for Eric now -- through the 20 years they never wanted to put their toe in that water of governing interfacility transports. When we joined the collaborative committee they did have that small oversight, basic protocol there. But it really doesn't delve into how much nuances there are. And it is under the -- you know -- sending facility and that I'm sure you get so much variation. You know, I can go either way on it. I definitely think having guidelines for people to use or things for them to review to are always helpful and I think it is in the best patient care interest. I think the problem becomes some of the providers that perform the interfacility transports, you know, have bucked this in the past because they think we are dictating what they have do. But I think from a medical direction and from our input we should have some input and should make sure there is patient safety and there are

standards and it would be nice to do things similarly. It is just like the collaborative, why can't we all kind of be on the same page and make sure -- maybe the doctor doesn't really know and maybe if they had a piece of paper that says this is the way to do it it would be helpful.

DR. BERKOWITZ: I mean, certainly I think everyone would agree that the medical control provided by the sending doctor would trump anything that would be in interfacility protocol. This would be kind of what would be -- in the absence of direction what would be the standard, or it would be hey, I'm going to follow the existing protocol and say sure that sounds great.

DR. MURPHY: And a kind of rudimentary thing so they have a template and concrete foundation to start on and there is always going to be some variation and things that add in, but I like that idea.

DR. BERKOWITZ: What do other people think?

MR. LAMARCA: I think for any transfer

we are doing obviously we have to have orders before we leave and that's usually written orders by the transferring physician. Are they always crystal clear? No. A lot of times is it following ALS protocols? Yes, they are. But it really doesn't involve -- it's between a unit at a hospital going to another unit at a hospital. It doesn't really involve EMS protocols, per se. We use a lot of it, but you can argue both sides of the case. We have had some issues dealing with a physician that has his orders and doesn't want some things done and wants other things done. That has created a problem, when we get into trouble is when they transfer a patient, we have to call into a hospital for medical control somewhere down the line, or drive into a hospital, and I know there are physicians that felt this is not in my charge, this is a private transfer almost. So it has -- we have had a lot of discussion with this at State level, some regions have done it, some have not done it -- well, others shied off of it. Normally

most of the discussions center around Albany Medical in the past because I guess a similar --

DR. BERKOWITZ: Yeah.

MR. LAMARCA: Lot of our transfers don't stay within the region, they go to other urban areas, New York City, Boston.

DR. VANROEKENS: I think it's a great idea to improve quality of care, but there is the complicating factor of jurisdiction. We have the right to regulate, but we have a right and duty to say hey, this is what we should be doing for interfacility transfers. I think it's a good idea. Westchester gets the bulk of the transfers from this region, Hackensack and other facilities in other states, to the extent you could involve some of them, it would be helpful.

DR. BERKOWITZ: Well, I think for patients going to New Jersey, it's immaterial --

DR. VANROEKENS: Well, we can say this is our recommendation for the interfacility transfer --

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DR. MURPHY: I would be willing to setup a TAG. I think we do need to have some representation and I think it makes sense Westchester and Hudson Valley that we do this open communication and form something together that works for both of us.

Mr. Murphy?

MR. MURPHY: I think it's a good idea. I think it's positive for patient care and universality. I think we need to think about -- you used the term protocol, perhaps guidelines is a matter of semantics, but a better term. I think there are some universal guidelines that should be put forth especially with regard to medications that practitioners may not be familiar with all the time, both the provider doing the transport and the sending physician that maybe sending the person. So if there was a universal guidelines of transporting with EPA, or propofol, or whatever it maybe that would be positive for patient care. And I think that if you do establish a TAG absolutely it should be physician based, but

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I think you need some representation for logistics and other nuances from the actual folks doing transports.

DR. BROOKS: We have been banting about this for about 20 years. ER to ER is a separate sort of transport and we as control physicians are actively involved, we know the medication and it's a little easier and guidelines would be easier. When you deal with interfacility transports from unit to unit upstairs you have to be careful. We used to have that in Alamo, there is a whole separate course the transportists took regarding nitro drips and not propofol at the time, but similar medication out of protocol for our involvement here. And if we get involved in those transports outside of ALS if something happens we are open to liability with medications that we are not usually medical director or medical control for. So just be a little leery of interfacility transports from an upstairs unit to upstairs units. It's just a thought, not that it shouldn't be done, not that it shouldn't --

but there is a lot of medication and stuff we are not usually involved with. We have our meds and that's what we deal with, we teach our medics that. But when dealing with propofol and Tridil drips and other sorts of weird antiarrhythmics and a bunch of other medications it's on us to accept them and make sure they get taught. So I think it's different ER to ER versus -- not that the interfacility transports up there from unit to unit shouldn't be addressed, but we have to watch our involvement in it. And we have been through this for years -- it's a just a caution.

DR. MURPHY: I think that is, you know, definitely an issue. Because sometimes you don't know what people are doing upstairs, but I think we need to protect our medics who are out there. They do need to involve medical control at some point and I think if there is a problem it's sometimes too late, you know. It's better to know it on the front end, but if we had loose guidelines -- not loose, but some kind of guideline for

them to have a mechanism of who to call and what to do is a positive.

DR. BROOKS: And they are not available, a lot of times private docs are not available --

(Everyone is speaking at once.)

DR. MURPHY: -- to help and to intercede because that's what we are here for, to help them out. I think that was the premise behind the original collaborative protocols, was to help protect the medic and have an avenue for them to have some backup and support. And if they are uncomfortable, they need to be able to talk to somebody and say, this doesn't make any sense, this maybe a drug I don't know, maybe they just did this process and I have no idea what this is.

DR. BROOKS: The question is whether they should be transporting somebody with a medication on board with a medication in drip they don't know. That is the question. At Alamo there was a special class that people had to take and sign off on under medical direction, it's scary, it's a lot more

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complicated --

DR. BERKOWITZ: This will help define the scope better, this process would be a process where we help define one of the medications that your guys feel comfortable doing, using it. And one of ones that maybe we don't include, if we don't include it there is a reason we don't include it.

DR. STUHLMILLER: Nationally there is no accepted curriculum for a paramedic doing interfacility transports. Each state has the choice whether or not they designate a paramedic at a level above -- if you will, forgive, the -- don't take that critically -- but above the level of 9-1-1 paramedic and New York State choose not to do that, other stays have. So there is many State courses and guidelines you can look at, including Connecticut. And there are two national certifications for a paramedic, CCPC, which is certified critical care paramedic, CFPC, which is a certified flight paramedic, neither of those have an education or requirement to sit for the course so there is

a void in the evolution of the role of paramedic in out of hospital care. And it's been one that New York has avoided, as you said, Fran, as has this REMAC for a while and REMSCO and everyone avoided because it isn't easy. If you could provide tools for a sending physician to use to guide the providers on how to care for some of these critical patients that would be valuable. And then also, who do you call when you get into trouble? Solidifying that system would be valuable and likely to be the receiving doctor if that receiving doctor is willing to take phone calls and manage out of hospital transport, which is variable as we all know. That's why myself and my colleagues and the air transport world are usually medical control for our providers and we provide them with guidelines that are pretty robust that thankfully the REMACs have allowed us to have our providers have different guidelines and different medical control. And I think part of that is because there has been no other option, there has been no other New York

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State or REMSCO sponsored solution. So I'll be part of the TAG --

DR. MURPHY: I was just going to say, does that mean you are volunteering?

DR. STUHLMILLER: I have been doing it for years, but --

DR. MURPHY: No, but I think it's good because it gives the other advent and you'll have stuff that is already out there. Again, some of the stuff is already there, you use it in flight and we can modify, adopt, or incorporate.

DR. BERKOWITZ: I would love to have involvement from the agencies because this is really just about protecting the medics with respect to the idea of what actually is within the scope this practice.

MR. LAMARCA: As far as the State, I sat on the SCT committee on the State level and State was not going to get involved in another level certification. They recognize by SCT, special care transport, is certainly care above the level of paramedic. However, in that void lies a lot of -- 90 percent of

interfacility work and so the State wasn't going into it, some regions did and some didn't. If we take a transport out of the hospital the medics have to be familiar with whatever is the meds that they are transporting. If they get into trouble it's usually because the patient's condition changed and they are looking for help. That's usually when they can try to call back to the transport physician, or more likely looking at calling medical control now, it's not to protect the paramedic, but to protect the patient. But often times the medical control physician is on the spot, hasn't seen the patient, hasn't seen the orders, doesn't know who is involved, and now you are asking them to interact with this transferring. So often times we are better off when we come into the medical control hospital rather than I'm halfway between here and there, what orders are you going to give me? I can't speak for you guys, but I'm sure you don't want us calling for orders on a patient you have nothing to do with, not even involved in

your facility. It's just because you happen to wear the role of medical control facility close enough for us to call you.

DR. MURPHY: I think we always have to, you know, be there for the patient. So if you guys are in a transport and you are headed down to say Westchester, for example, and you get before the Tappan Zee Bridge and something happens, you have to pull off and go to a facility and get help if you need help. And so I think this is all good communication, good -- you know -- opening of discussion so that we have some kind of template guideline assistance mechanism of what to do, some kind of thing for people to follow.

So, Dr. Holden, you are way up in the north, you want to come on the committee too?

DR. HOLDEN: Sure.

DR. MURPHY: And that way, you know, we have the place covered. We try and get -- you know, there are so many facility transports occur and I think opening this conversation is good. I think it's all good

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for everybody involved.

DR. BROOKS: Albany should be involved.

DR. MURPHY: Actually, that is one of the things, they are looking at, is do you make a protocol for interfacility transports? How do you do this? That whole conversation of Article 28, facilities sending patients, et cetera, et cetera. And it's a thing that everybody is looking at right now because it's very very important. I think we can start the discussion, form a TAG and start looking at it and make, you know, some kind of head way.

DR. BERKOWITZ: Do we need to vote on --

DR. MURPHY: No. We can just make a TAG. We will just make sure we put that in the minutes and those people who so nicely volunteered.

Next -- anything else in the open forum?

DR. ARSHAD: Just a quick announcement, Saturday, November 7th, EMS Connections Conference at Dutchess Community College. And there are a whole panel of physicians Dr. Papish, Dr. Berkowitz, Dr. Brooks, I'm

speaking there myself. It's for the community, help spread the word, Guy or Sharon are happy to --

DR. MURPHY: That also means medical control contact hours.

DR. ARSHAD: Absolutely. Seven hours, we'd love to have you. We will take care of food and all of that.

DR. MURPHY: It's Saturday?

DR. BROOKS: Saturday, Dutchess Community College, I think 8:00 o'clock on.

MR. PARRISH: November 28th, Ulster is having their EMS teaching day at Mohonk.

DR. MURPHY: Do you have to pay the facility fee to get in?

MR. PARRISH: No. It's $25.00 registration, includes two breaks and lunch and CME's.

DR. MURPHY: What is the date of that.

MR. PARRISH: November 28th, the Saturday following Thanksgiving.

DR. MURPHY: So it's that Saturday Sunday.

SPEAKER: How many CME's?

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MR. PARRISH: Two MAC, two medical and two general, so six CME's.

DR. MURPHY: Anything else?

DR. ARSHAD: Anybody else taking the EMS boards in a week?

DR. BROOKS: I take my --

(Everyone is speaking at once.)

DR. MURPHY: He is saying EMS certification. I know that Albany is putting in their -- what is it -- the CMGE? I'm misquoting it, the --

DR. ARSHAD: ECG ME.

DR. MURPHY: ECG ME -- I forgot that one letter -- for the final stages of having an EMS fellowship.

DR. ARSHAD: That's amazing, my program got reviewed in New Jersey and the fellowship I run, it's very exciting.

DR. MURPHY: Yeah. So they are putting forth the final stages of that so they can have an EMS fellowship. Any doc that goes through their residency program in emergency medicine you can go on and do fellowships and one is to do EMS and that's what they are

applying for.

Anything else?

So homework for next time, think about becoming the medical director, bring -- make sure you review the times for our new meetings, review the pie diagram because we will talk about that next time for our region and we can move forward on it and just, you know, reviewing the disposition designation.

And I think that's it for now -- and the new TAG that's been formed.

Can I have a motion to adjourn the meeting?

DR. BROOKS: Motion to adjourn.

DR. MURPHY: And second?

DR. WILSON: Second.

DR. MURPHY: Thank you everybody for coming. This was a great attendance, I appreciate it.

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


Yvette Arnold