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HUDSON VALLEY REGIONAL EMERGENCY

MEDICAL ADVISORY COMMITTEE

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MINUTES OF MEETING, held at the offices of Hudson Valley Regional EMS, 33 Airport Center Drive, New Windsor, New York, on Monday, January 4, 2016, at 9:30 a.m.

Yvette Arnold,

Court Reporter

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

DR. PAMELA MURPHY,
Committee Chair
DR. DAVID STUHLMILLER,
Helicopter Subcommittee Chair

WILLIAM HUGHES, EMT
HVREMSCO Executive Director
KAREN DELAUNAY,
OFFICE MANAGER

JEFFREY CRUTCHER,
QI Coordinator

GOOD SAMARITAN HOSPITAL
DR. DENNIS MAO,
Director

HEALTH ALLIANCE OF THE HUDSON VALLEY

DR. GUTMAN,
Physician Representative
ORANGE REGIONAL MEDICAL CENTER
DR. PAMELA MURPHY,
Physician Representative

PUTNAM HOSPITAL CENTER

DR. BUTTERFASS,
Director
MID HUDSON REGIONAL HOSPITAL OF WMC
DR. MARK PAPISH,
Director

VASSAR BROTHERS MEDICAL CENTER

DR. ARSHAD,
Physician Representative

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

MIKE BENENATI
ISRAEL KNOBLOCH
ANDY LAMARCA
MIKE MURPHY
RICHARD PARRISH
ERNIE STONICK

Proceedings

DR. MURPHY: We will bring the meeting to order. Sorry, I'm running a little late -- I was chatting too much. So thank you all for coming.

I know the minutes went out from our last meeting from November 2nd. Hopefully everybody got a chance to review them. I do have enough people right now to make a quorum.

So I would like to make a motion to accept the minutes with any corrections, deletions, or addition anyone has? Anything anybody has comment or anything on the minutes?

DR. MAO: Motion to accept.

DR. MURPHY: Thank you, Dennis. And second?

DR. PAPISH: Second.

DR. MURPHY: Thanks, Mark.

So this morning just a couple of kind of detail items, you know. As you know we had put forward with the help of many people -- Dr. Arshad, thank you so much -- and the New York State Department of Health and the great

Proceedings

TAG committee that was chaired by Dr. Bart, the whole process of long boards and spinal immobilization versus cervical spine protection and the whole process behind it. So the Department of Health finally put out letters to all the hospitals so that the information was disseminated also to that side of the fence, from Dr. Zucker, the commissioner, directly. It did include an algorithm for suspected spinal injuries and such and I'll pass it around so everybody can look at it. And that's what went out so you'll know what is behind the scenes they developed and received in the hospitals.

The last meeting we had here I had given out everyone the -- or September -- to everyone was available Dr. Bart's video on his educational program for the new spinal immobilization process and then Mike sent out the link via e-mail so hopefully everybody got it. And if you need it, please just let me know and we can give it to you also. It's a great program and if you want to use it and even bring to department meetings I think is

an important thing so everyone knows exactly what is happening out there and how the whole process came down. Dr. Bart was the SEMAC representative who chaired the TAG that did all the information behind it.

MR. LAMARCA: We do have the link put on our website --

MR. CRUTCHER: We can put it up there.

DR. MURPHY: Hey, Mike? Put it on the website will you -- no.

So that came down from the State so everybody can see it, it will be coming around.

Also, Karen sent out to everybody on the list serve the latest draft of the memorandum of understanding and that was the document that we have been creating to form some kind of real unity of what our collaborative protocols committee is all about and it is going to require me to sign now. And we were asking for this right from the beginning so actually this is something we have been talking about. Just a document that states, you know, why we are doing this, how it's

Proceedings

organized, how it's structured, the purpose, responsibilities, and it definitely delineates in there that we still as a REMAC are responsible for what happens in our region. Even though we are part of the committee and we all work on the protocols together there are going to be some regional differences, especially if you look at some of the outlying areas of some of these regions we have under the Hudson Valley. So the biggest thing in here -- and there is a reason why I wanted everyone to read it was they kind of want it to be all or none. So that when you join, you join, and you don't jump back and forth, back and forth. They are trying to make it very solid and so when we join, we are in. And to come back out we have to file a petition to leave the collaborative protocols committee or organization. And then with that letter we are going to have to have something immediately to the State to say these will be the protocols going forward and that's kind of like the fail safe if somebody leaves the

collaborative protocols group.

We are now up to everybody -- we are 18 regions now out of New York State so really the only people not in it is New York City right now. And they are not going to be in it because we are so different, we can't all be on the same page with New York City. It's a different apple, we are oranges up here in Orange County and such, they are apples, we can't be on the same page. But all of Long Island has joined and the last hold out in the Upper Northern Country joined so we are up to 18 regions now in that committee.

If anyone in the room does want to see what happens you can be on the list serve. You give me the e-mail address -- we do a ton of stuff e-mail wise. We have everybody discuss and weigh in and, you know, tell us what they think about changes and things we are talking about doing.

Mike recently has taken on the responsibility of being the overseer of our protocol committee and to be the real person totally intact with that committee and our

communication person and to keep me organized. And Mike will tell you, say we put out a thing and say we want to change the dose of ketamine for this. You'll have a pharmacist weigh in on it, you'll have prehospital providers, people that are executive directors of the regions, people that are on all different levels and certainly the medical directors and chair -- REMAC chairs. But it's a great discussion that, you know, how we piecemeal it down, dissect the problem, look at it from just its verbiage, to how feasible is it? Is it something that is going to work? And is it academically and educationally solid is it something that should be -- you know, is it something we should be moving forward.

So I think, you know, you can anything you want to add.

MR. BENENATI: No. I think you summed it up nicely. It's a good work group.

DR. MURPHY: Yeah. So after the SEMAC this past month in December we all sat down right after the meeting and had a meeting

Proceedings

and, gosh, now in the room there was twenty of us. I'm like God, this meeting is getting so big, it used to be like six of us. So it's great because really you have a lot of eyes looking at it and I think it's all, you know, excellent stuff.

And I think the thing that is also important for the prehospital provider, say you are working over here in the REMO area, or Hudson Valley area, or you know, the Upstate, you have the same protocols and basically everything is very much, you know, familiar so that we will have good overlap of coverage and I think standardization. I think it never hurts to have things be we are all on the same page.

So that was a long-winded conversation -- sorry. So the MOU was just so, you know, what I'm going to sign as part of that work group and protocol consortium and what we are doing.

DR. PAPISH: So the big difference, the only significant thing from what I read is what you are signing is essentially saying

that our previous ability to sort of have some variability is gone?

DR. MURPHY: No. You still have variability because of the region, so we can do different things. Like say -- what is an example, guys, help me out -- we elected not to do --

DR. PAPISH: Nitrous --

DR. MURPHY: Yeah, so we have nitrous and so no one else does, but we have an ability to do it because we had it before and so we worked it in as a process that we are not going to lose that entity.

Now, what they have done is taken the materials from David and looked at it so other regions might want to take and adopt it. Because he has given forth now I think three sets of data, the efficacy, how well does it work, and the whole nine yards. People are still concerned because of the whole reservoir and collection and stuff --

DR. PAPISH: The reservoir --

DR. MURPHY: Yeah. You are supposed to have this thing that sucks up this stuff --

Proceedings

MR. PARRISH: An accumulator whenever you use it so as you exhale it the room, especially the back of the ambulance, could have it and you could be sitting there as the provider getting dosed with it --

(Everyone is speaking at once.)

MR. BENENATI: One of the things they are going to do is pullout the policy and procedural portions and give them to the regions for control. So it's going to be -- there is going to be greater emphasis on the medical procedures and then we'll be able to do the administrative things the way we want to them. There is talk there will be a guide so if you don't want to rewrite your own you take these and put your name here kind of a deal.

DR. MURPHY: I thought of another one, MFI. What they had done in another regions, you know, they had two providers that were MFI certified. We are doing it one certification and one is educated because we just couldn't afford with the resources, you have to look at what you have. So other

regions have that luxury, we did not. So there is little things, so they do allow -- and you don't have to like -- there was another one.

Oh, with the interfacility transports, we are definitely going to back that out. You know, we had talked about it in the very beginning. We have never overseen that because it's really not under our purview and never dictated protocols for that. And they had one in there and we are like, Mike, this is a very iffy subject. It's really there just as an oversight, but it's not going to be giving any protocols because you have to allow the service director or whoever doing the interfacility transports to have their ownership of what they do and what they don't do. So we are still here as a protection for the prehospital guys, if anybody has a question, desire, or needs to talk to somebody they call medical control and get help and assistance. We are there to support everyone and backup.

But the only thing that is really

structured in there, that is really set in stone is you are in, you are in. No one foot in, one foot out. That's what I wanted everybody to understand I was going to sign off on.

But I think in the long run it made it so much nicer, the whole process of getting protocols approved through SEMAC, if you guys have been here long enough, have been torture. So now that as we come as this consortium it's so much easier and it's a really facilitated process that -- and I think it's easier for the State too, they are on the other side of it also. So that's what the two --

DR. ARSHAD: If I may piggy back on that? One of the interesting things that came out of the collaborative conversation was just an in depth conversation with the different regions on nuances, or the way certain folks are making application, or even some data and some experience. So, for example, one of the things we spoke about was C-PAP at the BLS level because it's obviously

something that has been approved at the State level. And the question was how variable is the penetration? How many folks are seeing this? How many are doing this? And we had an impromptu brain-storming conversation and how we might help advocate for the increased use of certain interventions. It was just a great information, a lot of fun folks around the table.

DR. MURPHY: I think the other important part of that is having it available for people that can do it, manage it, that have the medical director behind it and the equipment behind it and not making it mandated that we bankrupt one agency.

So the way these things always have gone, you start with a process, start with the issue and then, you know, see if it works. See how well it does and see what the penetration is -- that's a good way to verbalize it. And then eventually it's probably going to be state of the art at some point, but right now we are putting our toes in the water, just like electric EKG and

making sure everybody is on board and can transmit. So, yeah, that's the whole thing.

Arshad had come to the last meeting with me and I thought that was great. I think anybody that wants to be involved in those issues, definitely, you know, all eyes and ears, it's all good stuff.

So those are the old business issues.

I'm doing a lot of talking. Anybody with concerns or questions, or I can keep going on?

Service upgrade, we have none at this point.

The next thing on the agenda is evaluation subcommittee. Dr. Brooks has stepped down from that position, which she held for quite a while, years and years and years. So I need to have someone who would be interested in chairing the evaluation subcommittee.

Now, what is that? That's a subcommittee of our REMAC that meets as needed. It happens -- generally we will meet at least before this meeting if there is an

issue. And we do a lot electronically, again. But what it is dictated as, any issues that get forwarded to this office, to myself, or to the medical director individually, the evaluation committee sits down and reviews. Now, not all subjects are brought forward because there is some things that need to be handled at the agency level. So we bring it back to the medical director and say, this was brought forward, let us know what the update is and what you think. But there are other issues that might be more ubiquitous and more outstanding, so something the State brings to us, then the evaluation committee has to look at it. It's matter of researching the data, everything from the PCR, or provider, or whatever the instance maybe, just like in the QA process, it's the same issue, then we make recommendations. Probably the biggest ones that come along is if protocols are violated, or not followed or -- I don't know. We had a couple in the history of this place of like people bringing things out of their car and doing things to

people, those things came across our desk, or a real protocol violation where someone was not taken to appropriate setting, or delay in care, or really truly just not following protocol. So that committee now is open.

As I had mentioned the last time that we needed to fill the medical director. I do need to fill that committee chair position. I don't know what peoples' availability is, it's not a lot of -- it's not time-consuming, but it is -- it would have to be somebody that really wants to be involved in really looking at the protocols, really understanding the process behind it and wanting to, you know, work hand-in-hand with EMS providers because it's a much more provider responsive process. And we have brought in providers, we have interviewed them, we have gone and had the medical director involved when it's really serious issues.

But just food for thought, anybody interested? And I have some ideas that I'll approach people about. So something to think

Proceedings

about.

Helicopter committee. Dr. Stuhlmiller?

DR. STUHLMILLER: Actually no business brought to the committee so I am happy to report I have no report.

DR. MURPHY: Excellent. Nice. Jeff? QI?

MR. CRUTCHER: Cardiac arrest study is progressing well. By mid month we will have a full year's worth of electronic data to look at and four months worth of paper PCRs to review.

IN Narcan has been relatively active 2015 we had 44 reversals by BLS agencies --

DR. MURPHY: Forty-four?

MR. CRUTCHER: Forty-four.

And we distributed a total of 633 doses to agencies that come on board. Also working relatively closely with the Health Departments in Dutchess County and Sullivan County collecting and correlating data.

DR. MURPHY: Okay. I had -- I was reviewing -- I forget which journal -- and they were talking about nebulizing Narcan.

Proceedings

Did you guys ever nebulize Narcan? Two milligrams with three cc's of saline and nebulize it --

DR. ARSHAD: I wrote a paper, it was in PEC 2012, there are multiple routes for Narcan administration --

DR. MURPHY: Is it as effective?

DR. ARSHAD: It's not less effective. I had to think about that --

(Everyone is speaking at once.)

DR. MURPHY: Yeah, because that was the one question I had after reading the paper -- it wasn't your paper because I would have recognized your name --

DR. ARSHAD: I think the reason we had been more in favor, or let's just give it a shot, is we had all feared this violent reversal where somebody will wake up and punch you in the face and things along those lines. Whereas if they have some respiratory rate that doesn't require critical intervention and you put a nebulizer, they will self-titrate. So they will wake up enough so the respiratory rate rises and they

Proceedings

will knock it off and probably be okay in the next 45 to 60 minutes.

DR. MURPHY: Is that in lieu of atomization?

DR. ARSHAD: Yes. The data analyzed was before at atomization --

DR. MURPHY: Yeah, that's what I gathered. I thought it was interesting. Thanks, Jeff, that's a lot of reversals in a short period of time.

DR. GUTMAN: We had six last night coming from one crew from --

(The speaker cannot be heard.)

DR. GUTMAN: -- Mobile Life that brought in three within three hours. It was apparently just a party night --

DR. ARSHAD: From the same party?

DR. MURPHY: What was the pickup location?

DR. GUTMAN: Apparently Kingston was the place to be last night. We were very excited, it was some sort of record for them --

DR. MURPHY: It's pretty wild. I've had

parents come to me because they bring in the kids and the parent eventually shows up talking about the whole thing of getting on the program of having it in their home. You go --

DR. GUTMAN: Yes, the Lazarus kits. They came in dead, we gave them a Lazarus kit, it has that on it. Trying to explain the historical background of that to someone who just overdosed on heroin is fun.

DR. MURPHY: You didn't give an exam afterwards --

DR. ARSHAD: What we are seeing in a lot of the nationwide data with reversals is repeat overdose or reversals are on the uprise to repeat offenders.

DR. MURPHY: That's crazy --

DR. ARSHAD: There is this counter productive thought process everyone has it, employees, 9-1-1, CFR, my family has it, so is there is a comfort for more boldness, which is unfortunate.

DR. MURPHY: I think we just have to make it more expensive, it's because it's so

Proceedings

cheap.

MR. LAMARCA: Drug companies will take care of that --

DR. MURPHY: Mike?

MR. MURPHY: We did law enforcement program from Rockland so we had 27 last year --

DR. MURPHY: So that's police, first on the scene --

MR. MURPHY: First on the scene prior to arrival of EMS. And also what we did a few months ago is incorporated any Narcan reversals -- we referred the person to the behavioral health response team.

DR. MURPHY: The mobile crisis team --

MR. MURPHY: Right. And they reach out and make contact and see if they can guide them in any direction so we don't have the repeats.

DR. MURPHY: Yeah.

MR. MURPHY: It's brand new so I don't have any follow-up, but that is something that we started to do because we do realize, you know, it's not one and done so --

Proceedings

DR. MURPHY: I know, that's what the unfortunate part is --

MR. MURPHY: -- trying to get the behavioral folks to talk to them and see what the issues are and refer them to the follow-up in the county where --

DR. MURPHY: Yeah, it's pretty wild. Thank you.

So SEMAC we met on December 8th. One of the things I'll pass around, which some of you may have seen, is the pediatric minimum care standards the State put out now in the booklet format for people to try to have everyone on the same page in terms of upgrading our pediatric treatment at each one of the centers. There is a huge force of people doing this pediatric material and I'm forgetting their name -- Andy, do you remember who the woman is? I can't remember right now.

MR. LAMARCA: I don't remember --

DR. MURPHY: That's the physician -- there is a woman at SEMAC --

MR. LAMARCA: Martha --

Proceedings

(The speaker cannot be heard.)

DR. MURPHY: There you go -- thank you. It's a great amount of information, you can get copies of it, there is a contact there. They gave it to each one of us and wanted us to make sure we disseminated it down so everybody has that ability to access that information.

From standards committee -- the standards committee that was put through to SEMAC, we went over a bunch of projects that were out there. Suffolk EMT is still doing a twelve lead project. It's a process where it's not mandated, but available such that a BLS crew, EMT crew, can get involved in acquiring twelve lead EKGs and transmitting them -- not to read or evaluate, but if available -- if the equipment is available, if the teaching is available, and if the medical director is available and wants to do it it's under an educational module. Mr. Deloge, (phonetic), brought up it's not a scope of practice change, but it's being put on as a demonstration project -- or it

Proceedings

doesn't have to be demonstration project because it's not a scope of practice change. But it -- he'll get us information back about how successful it was, did it make an impact, and is it a process of treatment and does it expedite care?

The Epi-pen program is still going on as a pilot project under Dr. Dailey, that we talked about a long time ago. It came in the nidus of that was because of how expensive Epi-pens became once we started making it a BLS entity. So they made their own kit and he'll get back to us under that project to see how well it's working, is it something that will be effective, and it's like a tenth of the cost of what an Epi-pen normally is.

MR. HUGHES: We do have five agencies in our region that are participating in the Epi-pen.

DR. MURPHY: One of the -- a big conversation and it's kind of -- it's this program that's coming around, is the discussion of transportation of a pediatric patient and the standard of care and you'll

see in this pamphlet here that it's still a standard of care that they expect that the transport of a pediatric patient is in a device; i.e., car seat, or car restraint seat, some kind of device, not on the parents' lap anymore. And that whole decision of, the kid will be a projectile missile if something happens with a car accident. So they are trying to say if we can definitely make that a standardization that pediatric patients get transported in some kind of device.

We removed hypothermia from all the protocols -- as we expected.

We talked about the YouTube video -- Joe Bart's educational thing is a YouTube video we talked about for the spinal immobilization. And, again, we can get you the link if you want it.

We discussed blood regs and transfusion protocol, that came out. They know of one agency now trying to get on board with some of the local hospitals to be able to utilize it because it is a difficult thing to do, but

Proceedings

it is out there moving forward, it isn't an easy process.

MR. LAMARCA: Just note, the one agency secured an agreement with MidHudson Regional and it should be done --

DR. MURPHY: Excellent. Good job, Hudson Valley, good job Mobile Life, because that's a tough thing -- but it's all good.

There was a message or a dissemination of information from STAC. They had met right before the SEMAC meeting and they just wanted to reemphasis the process that we ensure that people are communicating patient arrivals to the ED and make sure they are calling in advance to let people know what is happening, what is arriving, what is coming, and what is going on, the whole nine yards, just reenforcing the whole communication issue of patient safety and treatment.

The State trauma report is out on their website. It's pretty impressive actually, this report from STAC. They put together all the trauma data and came up with the response times, their survivability, there is a ton of

information there and everyone can look at it, it's on the website.

They talked about the DOH putting out that letter I showed you this morning about spinal immobilization. And there are committees working on mobile integrated health, the whole community paramedic medicine situation. There is some issues there with long-term care and, of course, the nursing kind of -- let's say nursing --

MR. LAMARCA: Resistance.

DR. MURPHY: Nursing union resistance to the whole process taking off -- but I think it's going to happen in my humble opinion, it's only something that needs to happen.

And then -- just a couple of words -- we met, like I said, for the collaboration committee, the protocol committee and we talked about the MOU. The other thing is all meetings that we have will be recorded and will be placed in a drop box. So if somebody wants to see them, listen to them and, you know, and understand what came down at each meeting, it will be available in a drop box.

Proceedings

And the way each meeting will be -- we have to be better at giving more of a lead time for each meeting. We have been kind of bad that we just say the meeting is going on at SEMAC and then there is some phone meetings or go to meetings in-between. But we have to give people more lead time so they have a chance to be able to get onto the call or the meeting update.

The protocols we have decided will be, you know, looked at and approved on an annual update. Every two years there will be a full protocol revision, meaning everything single thing will be looked over, revised if needed, verbiage, the way it's written, any kind of tweaks, or things like that, but that will be on a two year basis. And, you know, it's always stuff being looked at, but a total revision will be done every two years. So that's the gist of SEMAC.

MR. LAMARCA: Dr. Dailey show and tell --

DR. ARSHAD: -- BLS again.

MR. LAMARCA: -- remember they discussed

Proceedings

that, the four milligram Narcan, the inhalent?

DR. MURPHY: Yeah, it's just changing the concentration and upping to four milligrams. Actually, I don't know why I didn't write that down. I talked about it. Just increasing the concentration there and so it's something that is still in the works.

But that is what is down the pike, we have a few little things we are tweaking in terms of medication dosages and things still, the ketamine thing is still up there and such. Can you think of anything else?

DR. PAPISH: Does the four milligrams they are --

DR. ARSHAD: So the gist is there is a new device or delivery system made by a different pharmaceutical company so what Dr. Dailey was advocating, in case of shortage there should be some backup option available. The other thing is the concentration is much higher so it's delivered over a very small volume, like one to two cc's, I think. It was very very small and the total dose is

four milligrams and administered by single nostril -- correct?

DR. MURPHY: Yes, single --

DR. ARSHAD: Single rather than two. So it was being put forward as a backup option in case of shortage.

MR. MURPHY: And it's a single unit so it's open container and squirt, whereas right now you have to open the container, screw two vials, and put the atomizer on --

DR. MURPHY: A one shot -- yeah --

MR. MURPHY: One shot deal, so we are looking to incorporate that more. So in the public safety law enforcement programs that's why --

(The speaker cannot be heard.)

DR. MURPHY: Yeah, I remember now because he definitely kept saying, I have no financial tie to this product --

MR. LAMARCA: That and the two twelve lead units he --

DR. MURPHY: Yeah, that was kind of interesting. They are a little bit expensive, but they are strap units that

literally you put around the chest and you hook it up, like you measure and put a loop and hook it up. And one was a strap with this little box and it delivers a twelve lead EKG. And the other is box, but you have to hook on the leads so you have to teach somebody to hook on the leads. Again, it's not rocket science, but it delivers and requires a twelve lead EKG. They were pretty pricey. They were not cheap. But it was two things they are looking at and that is what this whole Suffolk project is looking at, some of these devices.

DR. STUHLMILLER: Do we need to vote on that? You signing the MOU --

DR. MURPHY: I guess it's not necessary since we are part of the protocol. I just wanted to let people know what I'm signing because I'm signing us into this since we voted to be in there I guess that was -- we just never had a piece of paper. And actually, Mike was the first one -- was it two years ago now, Mike, right? He was like, but what about -- and so they really wanted

some kind of operational document so -- you know, some kind of document of understanding. And it worked out that it's finally put together and a bunch of people worked on it and it came out pretty good, I thought. So I wanted to make sure people understood what I was signing.

MR. BENENATI: There was also discussion with regards to the placement of tourniquets --

(Everyone is speaking at once.)

MR. BENENATI: -- and ultimately the protocol was slightly modified. They added the word should to be high and tight, so the tourniquet should be high and tight when it's applied on a limb.

DR. MURPHY: It was more so Andrew was concerned about the verbiage in that. But if you look at all the documents and most of the prehospital and definitely all the protocols from the military it's all high and tight.

DR. ARSHAD: I think the mild controversy there was in the ACEPT tactile conversation threads there was debate whether

the tourniquet should be applied proximally as possible, or just proximal to the wound or injury. So medical logic was if you apply it as proximally as possible and are unable to obtain hemostasis it gives you additional wiggle room to apply a second tourniquet.

DR. MURPHY: It became a little hot, I have to say, that conversation. I didn't know tourniquets could rouse such fervor.

Any or comments? No?

We have no new applications for new programs, Epi-pen, PAD, albuterol, glucometry, or Narcan at this time.

A couple of announcements and updates. We have had some requests from hospitals to provide CME and such and it's great that, you know, all these lectures and things are being done for the providers in each area. But one of the issues still in our CME and still in our project of how people acquire their CME hours is, we still require medical control contact. Meaning that a medical control physician is at the lecture, at the educational experience, and there as part of

that educational process. Such that they are there to answer questions, to make the information pertinent to what we do, make sure we are staying within protocol, make sure that we are providing good educational material. And that contact, I think, is extremely valuable. And when the medics come into the ER they get a certain amount of credit for discussing a case, going over EKG, going over a process, having you sign off, but the medical control contact hours from lecture were strict on the medical control physician has to be there. We had a couple of recent submissions for medical control contact hours that we are not going to give because there was no medical control physician there present or doing anything of the lectures. So come on, it's just a little bit of input we need to do, so I can't bend that rule, that's not something we will bend.

MR. HUGHES: The medical control physician is actually supposed to give at least 50 percent --

DR. MURPHY: Yeah. And it's a thing

where it's a whole discussion process. Even if you have outside lecturers -- what we did for ORMC, I had a national lecturer come in and what I did was do the lecture with them and just that way we make this pertinent to what we have in this area and, you know, talked off each other and discussed it so it makes sense and the poignant parts of how we utilize this information or process and make it relevant. I think that control -- medical control contact is very important for the providers. And just every time they approach you in the ER and every time they come up to ask you a question or discuss a case, that's all really good information, really good feedback, it ties us in, it ties in what we are supposed to be doing here. So I wanted to reiterate that we need to make sure we abide by those kind of basic issues.

Under kind of open forum and new business, I try to bring forward materials that are sent to the office. We were notified by Lee Burns that the verification process for Good Sam was they were unable to

pursue it. So just as of this point -- this letter was dated November 16, 2015, Good Sam lost their designation as a local area trauma center. They -- they were -- we disseminated that information, but they are hoping this facility will reapply for provisional trauma designation and get back their status. But it was a FYI move forward towards us.

And I think -- oh, you have handout up front of all the meetings coming forward for this year. Mark them in your little books. And hopefully we haven't made one over a holiday, we changed September so it didn't hit Labor Day again. So hopefully that will -- they will go off without a change.

Okay, open forum. Anybody want to bring anything forward?

MR. BENENATI: Just we formalized the protocol committee a little more. We will meet monthly, the third Thursday every month and the meetings are open. If anybody is interested in attending to bring ideas forth, join us. And we want to provide a monthly report to this group of what is going on.

Proceedings

There was a discussion with regards to Locums not willing to sign paramedic reports, this is an ongoing issue. If you could try and get that brought back to the personnel in your hospitals, that would be appreciated.

MR. PARRISH: What time?

MR. BENENATI: Good question --

MR. HUGHES: Eight-thirty.

MR. BENENATI: I think it was eight-thirty, right?

MR. HUGHES: Yes.

MR. PARRISH: Here?

MR. BENENATI: Well, next door.

MR. HUGHES: Yes.

DR. MURPHY: And I think -- oh. We definitely -- one of the things I brought up last meeting, the replacement of medical director. I know that I had -- or Dr. Papish has had discussions with people and I didn't know, Arshad, are you still interested or --

DR. ARSHAD: I'll throw my hat in the ring.

DR. MURPHY: And the other thing you can think about too is evaluation subcommittee.

Proceedings

I thought you would be great for that just because having that interaction with the providers it's a much more provider interaction so that was the other thing I was thinking about.

So this morning what I would like to do then is since we have a quorum is to be able to make a recommendation from this body for the medical director.

Now, I was having these guys laugh because no one -- I don't think anybody in the room here except for like Andy and you guys, prehospital guys, remember back -- didn't you guys make me go out of the room and they voted -- do you remember?

MR. LAMARCA: I don't know.

DR. MURPHY: It's too long ago --

MR. LAMARCA: Even if I did remember, I would just deny it --

DR. MURPHY: The only thing I was thinking was that Mark and Arshad, you would have to leave the room and we would have a discussion about making the recommendation from this committee because we will vote on

Proceedings

it. We will have an official vote, okay?

So I'll ask you guys to step out for just a second. Off the record.

(Discussion held off the record.)

DR. MURPHY: So all those in favor?

ALL: Aye.

(Discussion held off the record.)

DR. MURPHY: Back on the record. I had gone off record for just the discussion and I just gave everybody a little bit of background of everything.

So, Mark, we voted you to be the new medical director.

And if you would, would you be the evaluation subcommittee chair?

DR. ARSHAD: Of course.

DR. MURPHY: I think that is just great -- you would be top top in terms of that.

The decision rested upon more so I think these positions have to be from people that have been here a while. And so I think this will all go together and you are such a valuable tool we have to have you in there. And Mark has been around us -- and he used to

Proceedings

have hair when he started with us.

But thank you guys and I appreciate and we look forward to working with you and we will make sure you are on all the list serves and such.

Again, on behalf of the region and all the providers, thank you very much, it will be very helpful.

Any -- okay, any other info? New business? Anything anybody wants to bring forward -- oh, you want to talk about your little card you showed me?

MR. HUGHES: No, not necessarily. Nothing has happened yet, I was just talking to you about it.

DR. MURPHY: Okay, anything else?

A motion to adjourn?

DR. PAPISH: Motion to adjourn.

DR. GUTMAN: Second.

DR. MURPHY: Okay, second. Thank you all for coming, that was a record one hour meeting.

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

Yvette Arnold