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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, March 7,  
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 STUHMILLER,  
Helicopter Subcommittee Chair

DR. MARK PAPISH,  
Medical Director

WILLIAM HUGHES, EMT  
HVREMSCO Executive Director

KAREN DELAUNAY,  
OFFICE MANAGER

JEFFREY CRUTCHER,  
QI Coordinator

BON SECOURS COMMUNITY HOSPITAL

DR. CRAIG VANROEKENS,  
Director

CATSKILL REGIONAL MEDICAL CENTER

DR. VOHRA,  
Physician Representative

GOOD SAMARITAN HOSPITAL

DR. DENNIS MAO,  
Director

HEALTH ALLIANCE OF THE HUDSON VALLEY

DR. GUTMAN,  
Physician Representative

NORTHERN DUTCHESS HOSPITAL

DR. WILSON,  
Director

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ORANGE REGIONAL MEDICAL CENTER

DR. VOHRA,  
Physician Representative

ST. ANTHONY COMMUNITY HOSPITAL

DR. VAN ROEKENS,  
Physician Representative

MID HUDSON REGIONAL HOSPITAL OF WMC

DR. BERKOWITZ,  
Physician Representative

VASSAR BROTHERS MEDICAL CENTER

DR. ARSHAD,  
Physician Representative

WESTCHESTER REMAC LIAISON

DR. ERIK LARSEN,  
Physician Representative

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

DESIREE LEONE-STOLL  
KIM LIPPES  
RICHARD PARRISH  
ISRAEL KNOBLOCH  
ANDY LAMARCA  
MIKE MURPHY  
ERNIE STONICK  
DAVE VIOLANTE  
RICH ROBINSON

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Proceedings

DR. MURPHY: We will bring the meeting to order. Thank you all for coming this morning.

We have a quorum so what I would like to do is have a vote on the past minutes from the meeting and accept any revisions, deletions, corrections.

Any additions, anything anyone wants to add? And if not I'll take a motion to accept the minutes.

DR. VANROEKENS: So moved.

DR. WILSON: Second.

DR. MURPHY: Thank you. So I know that --

DR. LARSEN: Do we have to vote all in favor?

DR. MURPHY: Yeah -- all in favor?

(Everyone is speaking at once.)

ALL: Aye.

DR. MURPHY: It's unanimous.

It feels like January was so long ago. Since that last time we've had a few things going on. We definitely have new protocols coming through, but I'll save that for later

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Proceedings

on down in the meeting when we do SEMAC and we will talk about it.

The things that have been more pressing since the last meeting was -- as many of you know -- the whole Trans Care issue.

Initially we were told that Trans Care was going to remain in the Hudson Valley under a new name and then the end of that week we were told they were gone. So that was a huge issue for certain parts of the area and impacted some people a lot more than others. But it just goes to show how quickly things can change in just such a short period of time. So it's something we have to keep on our radar and something we have to always be supportive of. And one of the things that was amazing was how quickly and how there was no interruption of service to the areas that Trans Care was involved in and that is kudos to everyone out there. And I know there is a lot of you in the room here that worked hard and diligently to get all that happening and help the medics that were now displaced. So it's really kudos to the area and to the

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Proceedings

region and to the State Emergency Department, Lee and her staff. And I know the guys were out there doing everything, so again, thank you to everyone. And it was impressive that there wasn't more of an impact -- you are very noisy this morning.

MR. HUGHES: I know -- sorry.

DR. MURPHY: Do you want to say something? Okay.

On the -- just to keep with the agenda, no service upgrades today.

We did have one new agency or one new business in the Newburgh area that is applying for a PAD site, which we put the application forward. What was it?

MR. CRUTCHER: Armitage Mechanical --

DR. MURPHY: That's it, thank you. Even though I just signed it you would think I remembered the name.

Evaluation subcommittee report -- you did -- you snuck in on me.

DR. ARSHAD: So if you could help me walk through this --

DR. MURPHY: We had a couple things come

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Proceedings

up, but we reviewed them both and what happened was is we felt both could be handled at the level of the agency and their medical director. It was nothing of any significance that needed to come to the regional level.

You know, people send us things all the time and it's fine, you know, it's good. Actually, I don't have to get them all, but I look at all of them. They always pass them along to me.

I think communication is always very important and I think, you know, whether it be something huge like Trans Care leaving the area versus, you know, somebody being pissed off at their service director and sending me a nasty gram, these things happen, communication issues and sometimes there is not an issue, again, so send those back. But we will always get in touch with the medical director of the service if we feel it has to be handled at that level and bounce it back because not everything needs to come to the region by any means.

DR. ARSHAD: A couple small issues being



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Proceedings

dealt with internally.

DR. MURPHY: This was just those two things. So Dr. Arshad has taken over as evaluation subcommittee for people that weren't here and Dr. Papish is the new medical director for the region.

Helicopter committee report.

Dr. Stuhlmiller?

DR. STUHMILLER: No business before the committee so I have no report.

DR. MURPHY: That's easy.

Quality improvement. Jeff?

MR. CRUTCHER: The only current thing that I have is we had a phone call about a week, week and a half ago from a small BLS agency asking about these new collaborative protocols and if they need to be involved with them. So we are addressing that. We will be going out and doing a training for that agency in the very near future.

DR. MURPHY: That's interesting. Where were they when I did all of those BLS rollouts?

MR. VIOLANTE: One of the things we have

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Proceedings

done in collaboration with the region at county level for Dutchess and moving to the county level for protocol committee is developing a way to put out BLS friendly collaborative protocols. So that BLS providers can come to the site, look at it, see them and actively -- we are looking at pushing out information to all BLS agencies, squads and providers as well so we are a kinder, gentler, friendly region including them in what we do. It's not just at the ALS level anymore and it truly is the EMS.

DR. MURPHY: Yeah, I had hoped the message had -- was out there the last time we did them. We actually did ever single --

MR. VIOLANTE: You did a lot of them --

DR. MURPHY: Well, we did every single county just to open up the forum and make sure people were not scared off by it. More and more we get into -- I'll talk about this again when I talk about the collaborative meeting we just had -- we definitely are involving BLS more because it's such an integration of services now and there is more

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Proceedings

and more services coming down the pike for BLS so we have to have everybody on the same page and not to be scared. We are trying to upgrade their ability, their level in congruence to the State curriculum.

MR. VIOLANTE: And what is hard about BLS is every year, if not more often, they change their leadership --

DR. MURPHY: Yeah, I think that's part of the problem.

MR. VIOLANTE: -- to sort of keep up with that.

DR. MURPHY: Andy?

MR. LAMARCA: I think we discussed that the BLS agencies are underneath some aspects of the collaborative and the collaborative is so massive -- we were going to try and put this on the region website, I think five or six of our collaborative protocols that have a BLS component. In between all of this the State finally woke up -- Rich, you didn't hear this -- but they have released the new BLS protocols and trying to let a lot of the agencies know. So I think one of the first

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Proceedings

things is the BLS service is to be pointed to the State website for BLS protocols, hemorrhage control, spinal, a lot changes --

(The speaker cannot be heard.)

DR. MURPHY: I forget who was complaining at the meeting, at SEMAC --

MR. LAMARCA: Everybody --

DR. MURPHY: -- it wasn't so easy to go on the website and do it.

MR. LAMARCA: It's not difficult.

DR. MURPHY: It seems like that was the answer back, it wasn't difficult at all. You go do the section --

MR. LAMARCA: These are the same people that find minutiae in the YouTube somewhere --

DR. MURPHY: So it links you right to all the BLS protocols, which is nice.

MR. LAMARCA: This took them eight, nine years to --

DR. MURPHY: Yeah, it was just ten, but they are all up-to-date as of our SEMAC meeting --

MR. LAMARCA: Well, subject to change --

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Proceedings

DR. MURPHY: That's the first time in a long time though they have been totally up-to-date so it's a big undertaking. That's why the collaborative protocols is good for us to keep up to snuff with all the protocols, that was tough in the beginning.

Protocol committee? Where is Mike?

MR. VIOLANTE: Not here.

DR. MURPHY: Are you doing the meeting?

MR. VIOLANTE: I think we just did.

DR. MURPHY: There is a few other things, right, you want to talk about? There was advisory for --

(Everyone is speaking at once.)

DR. PAPISH: There is a drug shortage as usual for vecuronium so we just put out an advisory that agencies that couldn't get vecuronium could use rocuronium so -- until the drug shortage ends.

MR. VIOLANTE: We are also changing the exam, the protocol exam we're administering, that is now going to be open book exam, but we are restricting the time limit. And we are also going to have the exam here in the

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Proceedings

office or -- excuse me, the protocol training office for people to look through in case they need to search something through. We felt this was a good educational option and ability for what people are actually doing in the field, plus that's the way our physicians and PAs and NPs take the exam and look at it and it's working for that group of people. But some of the other stipulations will still be in effect. If you fail, you can't come back and take it unless -- for the first time I think it was a week has passed and you get authorization from your agency and they have gone through some training with you. If you fail it a second time you can't come back for 30 days, I believe it is, after that. And so those things will still stay in place and that's going to start effective immediately I think, Bill? Yeah?

MR. HUGHES: Um, um.

DR. MURPHY: And the State is redoing their exam too. That was one of the e-mails we received was who would like to offer to do some of the exam revision.

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Proceedings

That brings us kind of to the protocol committee. We had a collaborative meeting after the last SEMAC last week on the first. And going forward we just put out another draft of the recent revisions. I'm going to take Karen's list and send every one of the physicians on the group a copy of what the latest revision is. There isn't a great deal of changes, but there is a few additions.

One thing that they want to try and put through -- its going to have to go to the State first -- but patellar reductions in the field. So any patellar dislocations, they have written a protocol how to have the medic reduce the patellar dislocation.

Pulmonary edema, they changed some of the treatment algorithm. And what was included is I actually do in the ER all the time is rapid nitro. So renal failure, people that have blood pressure through the roof, pulmonary edema is giving them nitro administration back to back. We have criteria there for depending upon their blood pressure how much to give. And including

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Proceedings

Albuterol in there for somebody who is wheezing that you feel could, you know, benefit from Albuterol treatment that is going to remain.

The blood pressure standardizations, we are going to try to have it remain the same throughout so we have in most of the other protocols blood pressure as it remains, 120 millimeters or greater, so we are going to try and standardize that so it's not different and all over the place.

We have altered the definition of -- rather than medically facilitated intubation back to RSI, like most people have done.

Medications are going to be still a purview of the region because there is times when our medications might be different from others and people may not want to be on board with ketamine and so they are not making some of the medications mandatory. However, they will be part of the formulary that people can use it if they so require or want to.

And we are putting through a response to -- instead of using solumedrol switching



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Proceedings

to decadron and using dexamethasone as most people are doing now both in oral and IV format, but oral especially for the kids.

Dr. Papish talked about the rocuronium vecuronium controversy -- or sorry -- shortage.

DR. PAPISH: It's not very --

DR. MURPHY: It's not very controversial. It does have a longer half life, that's why people don't grab it --

DR. PAPISH: It's really more post --

DR. MURPHY: Yeah, for keeping them down.

So the timeline is -- so I'm going to send you out what we have up until today. There is still some revisions coming, wording, some -- you know -- nomenclature in the way things are written because the basic tenant of it is there. So I'll put it out to you guys, you can look at it, and next meeting -- is June 6th. What we will do is vote on this then. So I'll sent them out to you guys, I'll get the e-mail addresses -- he just sent it to me last night -- I'll get the

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Proceedings

e-mail addresses today, send it to you so you can all review it, after that we will vote and go through the 30 day period. So we are looking at September along with the collaborative committee that we all submit these to SEMAC. So remember even though we are part of the collaborative protocols committee we still have to submit as a region, so following that structure and that specific time frame that is delineated in the protocols by the State. So we have to still follow that process.

Any questions? Concerns?

But I'll send it all out. Everybody here, I'll send you a copy so you can all look at it. And it's a lot -- the format is still the same we just kind of cleaned it up a bit, tried too make sure everything is standardized. But it's hard, you look at these things and you still find things that are wrong so that's why the more eyes looking at it would be great.

DR. ARSHAD: Was there much additional talk on training videos and --

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Proceedings

DR. MURPHY: Yes. Oh, yes, sorry. Go ahead --

DR. ARSHAD: No, I was just --

DR. MURPHY: Yeah, we are talking about that idea. I know Chris came to you. Christopher Folger is from the Upstate region. He has been graciously doing most of the rewrites for us. And so what some of the problems have been in the future -- or in the past was when we have the rollouts to make sure everybody is on board and gets the same information. So what we decided was we'll do educational videos, so that everybody uses the educational video and nobody has to reinvent the wheel, you know? So we can bring it to our corps, bring to our agencies, bring to our regions, our county committees and utilize them. So -- do you want to say?

DR. ARSHAD: Yes. Our brief thought was just to coordinate the training and make it easier for agencies both at the BLS and ALS level is to create training videos via simulation. As you guys know, we do a fair bit of CME at the simulation center in

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Proceedings

Wappingers Falls. And as you guys review the protocols if there is any interest or any physicians who are interested in creating scenarios or actually going to the center and filming some of that stuff, we will record scenarios various trainings and bundle them into either video pod cast, webinars, or things along those lines and put them into a forum easy accessible to any providers across the State. Like patellar dislocations, that would be --

DR. MURPHY: Yes, that would be a perfect one. We have to get that approve by the State first --

(Everyone is speaking at once.)

DR. ARSHAD: -- showing somebody how to do that rather than describing it in paper, which is completely different.

DR. MURPHY: Yeah. And I think, you know, if anybody had used, you know, Dr. Cushman's spinal immobilization, you know, revisions and how the protocol changed and just having spinal precautions and that was a great modality to be able to roll it out. So

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Proceedings

that's what brought up the idea and then they know Dr. Arshad has some lovely equipment available so that's why we are looking in that direction. And it will be, you know, all of us training and trying to do it, but I think it will be a great venue and easy for people to get to. Nobody has to show up to a place, you can go on-line and -- bam -- look it up and learn, learn, learn.

DR. ARSHAD: And then we should be able to get CE credits for folks that participate in that as well.

DR. MURPHY: Yeah. As long as we apply ahead of time and we have the exact format, you submit, you know, what is there and the time frame and what is going to be there really it will be us instructing so they will be able to get medical control contact hours too. The only problem is there is no back and forth. However, what we were talking about was maybe some of the time we do it people could come and watch it being filmed too and have some interaction there. Because then people could ask questions on real time

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Proceedings

and I'm sure it's the same questions other people are going to have outside.

DR. ARSHAD: Absolutely --

MR. VIOLANTE: I may have missed something, is there any work towards a collaborative test, testing process?

DR. MURPHY: I don't think we talked about that, no. No, it has not come up. I can put it on the agenda though because just like we want to have everybody learning the same thing it might be very permissible that we use a similar test bank, but no, actually we didn't talk about that. We definitely talked about the setup of how to roll the stuff out and make sure we are all on the same page, we are following the timeline and that we, you know, have people moving forward with new materials and always having time for people to catch up and then a drop dead date when things have to go forward and that's when you should be using the new materials. But, no, we have never talked about testing.

MR. HUGHES: On the next release it might be more conducive because what we have

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Proceedings

done is taken some of the regional procedures out of the protocols and that's going to be separate. So it will just be medical protocols and then there each region will have its own set of procedures in different situations that are currently in the protocols.

DR. MURPHY: We are definitely separating out the administrative kind of regionalized how to do things versus just the protocols so it stays standardized.

Erik?

DR. LARSEN: When I realized we didn't have a test to test Westchester docs for their, you know, MAC certification I just stole the one from Hudson Valley --

MR. VIOLANTE: Borrowed --

DR. LARSEN: What?

MR. VIOLANTE: Borrowed.

DR. LARSEN: Sorry -- borrowed. And that's basically what we are using so I mean I think we should be done for the whole area.

DR. MURPHY: Yeah. I think the only thing that will be different is each region

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Proceedings

has their specific kind of how to do things from our administrative -- and what is the other name of that book?

MR. LAMARCA: Policy and procedures.

DR. MURPHY: Yeah. Well, that whole thing of things that are specific to our area is not going to be the same as Mountain Lakes or REMO, those are the things that will be more specific for our exam.

Andy?

MR. LAMARCA: When I was Upstate I checked six regions on collaborative, with three more in the wings coming on, again, eighteen regions in the State. I think eventually everybody except New York City will be in. It seems if we could get that exam established now before new regions come in it would be better because then they have to accept that as a contingency of becoming part of the collaboratives.

DR. MURPHY: You are going to be surprised, New York City finally sat in. He is looking to do it. He's taking the New York City protocols and our protocols and



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Proceedings

said there is little difference, Dr. Marshall. So he sat in the collaborative meeting.

The two that will be a problem Suffolk and Nassau. Robert Delagi (phonetic) had come and he is like going to take a look at them, but he's like, Pam, they already put up a stop sign that they are not even going to render an opinion, they are not even going to look at them. So it's actually -- Dr. Marshall doesn't feel like there is a lot of difference between New York City and --

MR. LAMARCA: That's because he is reasonable, that's not necessarily what is going to happen though --

(Everyone is speaking at once.)

DR. PAPISH: The entire state is all doing one thing and Long Island is the only area not doing that thing. At some point someone in the government will say --

(Everyone is speaking at once.)

DR. ARSHAD: They are not doing it just to be obstinate. Bob Delagi and his protocols are quite advanced. He's been

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Proceedings

doing things at BLS and piloting various studies 10 years ahead of any of us.

DR. PAPISH: So join us and advance us --

DR. MURPHY: Yeah. I think -- I think he is going to be one of the people moving forward that wants to do it. I mean, it's just really his -- the corp is behind him and the group is behind him, the service is behind him, that have given him more of the lip. But, yeah, it's an issue where he is all for it. He actually sat in on our meeting too so --

(Everyone is speaking at once.)

DR. PAPISH: The future of all medical care is getting rid of variation if you listen to all the sort of talks of how we save money in the world, how we improve care overall, if you get rid of the variation and everybody is doing the same thing then you can study and know exactly what is working and not working and change it, instead of piecemeal little bits of things that really don't change anything over the general

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Proceedings

course. We are all becoming standardized and I think over time we will see somebody say there is two counties left, everybody needs to do it.

MR. LAMARCA: Long Island had the highest number of ALS not using controlled substance. And, again, they were dragging their feet and giving Bob a problem too. So for as progressive as they are in certain areas they are also kind of behind the curve.

DR. MURPHY: Yeah. And it's kind of just they are rooted in their processes they have been doing so they really put up a block of taking on controlled substances and that's been a huge battle, actually, on Long Island, which you wouldn't think so, but it's true.

Okay, also -- so I think that's the end of protocol.

Anything else? That's about it?

So also under new business, we had another significant event occur in the region that I need to apprise you all of. We had a turnover or a problem with the administration and leadership at BVAC. And for a short

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Proceedings

period of time we had to review, sit down and meet and talk with the State about what was going to happen. There was problems with 24/7 coverage, there was calls not being covered, there was lack of paramedics on calls.

And as you know from before, we had an issue with their controlled substance program and -- controlled medications. And so this morning I have with us the gentleman that has been hired to be the new EMS manager at BVAC and has submitted to us and to the State a process for improvement for remediation and to rectify the things that were missing and outstanding.

And I would like to introduce Graham Hardy.

MR. HARDY: Hello. As you can all imagine, in my position this is my first meeting and they expect me to talk.

So yeah, we just hired yesterday an additional three per diem paramedics, last week we hired another per diem paramedic as well as two EMTs in order to cover the

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Proceedings

understaffing issue we had previously. I kind of had to hit the ground running in my first week since I started last Monday. I have been in really close contact with Rich from the State -- some might argue a little too close contact. I think he says 12 phone calls in one day maybe. And we are actively seeking resolution to the narcotic issue that has come up in the past. And we're just trying to resolve all these issues and I look forward to getting through them.

And my number is out there if anyone has any questions, concerns, commendations they want to pass along, you are welcome to it.

DR. MURPHY: Yeah, I think one of the biggest things was right on the heel of Trans Care this implosion at BVAC pretty much sent Lee Burns more gray hair. She was like -- while I'm driving home from SEMAC Graham calls to tell me he took on the position. I texted her immediately that things are in the works and between Rich and you I'm very optimistic we can make this work. We will be having to setup some kind of plan of

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Proceedings

oversight just to make sure we touch base with you and get things back on-line and in order and make sure all the calls are covered because it's a very important area. We don't want to see anything happen to BVAC, we want BVAC to be around. It's not ours, or the State, or anyone willing to see services go to the wayside, we want to include support and we want, you know, this to continue. It's all for our patients and our families and people that live in the community so we want that to continue on.

So thanks, Graham, and you spoke fine in public, don't worry.

MR. HARDY: I've been practicing a lot.

DR. MURPHY: I received a notice from the Department of Health that Vassar was given a provisional support by STAC committee to become a level two trauma center for adults, effective February 29th. And they will have one year from that date to request the site visit by the American College of Surgeons, make sure everything is up-to-date and up to snuff and that's what would move

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Proceedings

them forward. But this is the first step in that process so I wanted to pass along the information to everybody here.

Under new business, do you want to --

DR. PAPISH: Yeah. You know the RTAC meets -- what is it, quarterly or --

DR. BERKOWITZ: About quarterly.

DR. PAPISH: -- and they kind of operate relatively independently of us. And both agencies obviously have a lot of vested interest in the well-being of EMS and trauma care. I was wondering if it would make sense to have a standing -- whether it be a physician on the committee, or just a standing report from the RTAC when they meet because we don't really interact with them we just hear about things from the meetings, but it's sort of the whole trauma system that is meeting and not specifically directly to us. So any objections? Or do we have to bring that to a vote?

I don't know if the question is whether let them have a seat, or have somebody give a report. Several of us go, you know, to the

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Proceedings

meetings anyway, but it would be a good idea just from communication standpoint to know what they are thinking and doing.

DR. MURPHY: Yeah, like we are saying, the communication is huge. So we are all on the same page.

Erik, you are on the committee and, Jon, you too, right?

DR. BERKOWITZ: Yeah.

DR. MURPHY: So I think between one of you, each time -- what we could do is call upon you, make sure we are on the same page, when you are at the meeting you can kind of convey the kind of what the stuff we are doing.

I think it became an issue with the protocol for hemorrhage control. And actually we had a big talk at SEMAC -- which I'll talk about in a little bit when I do SEMAC -- and it was because of issues from STAC that came up that the protocol had been accepted by SEMAC, but when STAC looked at it at the State level they wanted a couple of just points clarified, which we went over and



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Proceedings

approved. So I think that's a perfect example of where the communication has to go back and forth so we are all on the same page and doing the same and have input from each. So I think that's a perfectly viable thing to do.

DR. PAPISH: So does it need any kind of a vote?

DR. MURPHY: Uh-uh, because it's an open meeting. At this meeting -- anyone can come to this meeting at any time. There is only a restricted audience for voting or passing material, so that's the only difference.

DR. LARSEN: Well, it probably should be put on the agenda as an official item --

DR. MURPHY: We can put it as STAC report just like --

DR. LARSEN: I don't know if it is STAC report or --

DR. BERKOWITZ: RTAC --

DR. MURPHY: Sorry, sorry, RTAC report. And we can have that inclusion for sure.

DR. LARSEN: Okay.

DR. MURPHY: I'll make sure Karen adds

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Proceedings

it.

MR. HUGHES: Who is going to do that?

DR. BERKOWITZ: I can, that's fine, or Erik.

DR. MURPHY: Whoever is here.

DR. BERKOWITZ: We will make sure one of us --

DR. MURPHY: You can always pass along the information if you guys can't be here that one of us gets the info.

SEMAC report. So kind of in line with what we have been mentioning a little bit, we reviewed the New York City protocols and the Suffolk County protocols, not too many things were different there. Interestingly enough Suffolk had to add in IO so they can't be that far along if they didn't have the IOs in there. And they are going back to D50 instead of D10, they don't want D10, which is interesting. Whereas all us are going the other direction. And you know, so we went through those protocols and talked about what the changes were and that's when Dr. Marshall started discussing and asking everyone in the

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Proceedings

room could we all join the collaborative protocols committee? Because when you put the protocols side by side there is not many changes. So just like you are talking about there shouldn't be a lot of obstruction to moving in that direction.

They did rescind -- the State rescinded two protocols, the treatment of hemophilia and biphasic AEDs, they were so out-of-date and not utilized. So from the State protocols those were removed -- 970-1 and 970-2 if somebody is into the numbers.

We discussed, Daniel -- I don't know his last name. Do you remember his name? The gentleman from STAC, the doctor? Daniel? He is a trauma surgeon. So he had a whole -- I can't believe I can't remember his last name -- about the tourniquets. And what we had put in the protocol was that the tourniquet should be applied on the limb proximally and as possible high and tight. And we revised that to be two to three inches above the wound -- visible wound, not over a joint. If you cannot decide where the exact

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Proceedings

location of the bleeding is there is not to be any exploration, but just provide the tourniquet to stop the bleeding as high as you need. However, if that doesn't control it you can apply a second tourniquet adjacent to the initial one. So those changes were put in there and revisions and so it will be in the material I send you guys with the attachment.

So that was a whole discussion of STAC and the whole input into making sure we are all on the same page.

They are looking at some Part 800 revisions and updates for both equipment and supplies.

Someone brought forward a discussion of Life Vac. I don't know if you guys have seen this apparatus. It's a suction apparatus to remove foreign bodies. It's like you put the device over the person's mouth and nose and it forms a seal and it has a suction device like a plunger --

MR. LAMARCA: It's a toilet plunger --

DR. MURPHY: Yeah. Yeah --

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Proceedings

(Everyone is speaking at once.)

DR. MURPHY: -- which will remove foreign bodies from the airway. So one agency had put a question forward, could that be used in substitution for traditional suction, that part of the equipment list? And we voted unanimously no because it's not the same thing. And we actually had a little -- we had a demonstration, but not on a person so that people could see.

The whole point about CPAP, it will be a regional level approval. And, you know, as you know, can be taken on by BLS agencies as long as it's applied for, approved and regionally stamped off on, but the educator must be CIC approved for the education of that skill.

And we still have no one that's applied in our region, right?

MR. HUGHES: No, we have two.

DR. MURPHY: Two --

MR. VIOLANTE: We are doing it now.

DR. MURPHY: Okay. Who is the other one? Who is the other one?

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Proceedings

MR. LAMARCA: We have it for our BLS --

DR. MURPHY: Yeah. Well, your agency, yeah.

There was some changes at the State level under Lee's office, some changes of personnel, nothing more --

MR. LAMARCA: Rich is here, you are one of the changes.

MR. ROBINSON: I'm one of the changes, I won the prize.

DR. MURPHY: What is the prize?

MR. ROBINSON: I am the acting EMS program director down in Maryland, our immediate supervisor got moved over into hospitals.

DR. MURPHY: So you are going up.

MR. ROBINSON: Sort of. I have an office as opposed to a cubicle, no window anymore though. I can't see the Hudson anymore --

DR. MURPHY: They were discussing that --

(Everyone is speaking at once.)

DR. MURPHY: That's why they have the

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Proceedings

seatbelt on your chair.

One of the issues that came up was -- from Dr. Burns was submission of PCR's is still an issue. You know, they still are trying to encourage everybody to make sure they submit PCR's.

They talked -- again about blood regulations. There is now two agencies that have moved towards all the proper paperwork and relationships with the hospitals. One agency is already on board and using the new regs.

And this was an issue from STAC. STAC wants to make sure that all trauma codes and alerts are called into the hospital ahead of time so that we follow those trauma protocols. And if people meet the criteria that we are trying to get them to a designated trauma center and if not, if we have to go to the closest facility, that we do call in and make sure that we are getting enough advance notice and being able to be ready.

DR. PAPISH: The big push from them to

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Proceedings

improve the number of pediatric patients that are trauma patients being transported to pediatric trauma centers. They did a study and said the average time -- do you remember --

(Everyone is speaking at once.)

DR. PAPISH: -- the closest hospital, get stabilized and then transferred. But the overall amount of time ends up of being between five and seven hours as opposed to the --

DR. MURPHY: The golden hour. Yeah. I think unfortunately we have a lot of work to do in that arena.

So like we talked about before, that BLS protocols are all updated, it's pdf version if people want to download it.

The next SEMAC meeting is May 24th. And the EMS memorial is May 11th in Albany and they wanted to encourage people to please attend. She said, unfortunately, they have to put another limb on the tree of the memorial because there is just quite a few number of people they are adding in this



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Proceedings

year.

PAD sites and all that, we did, so that's done.

Okay, open forum. Any issues anybody has wants to bring up, discussions?

MR. VIOLANTE: Yeah. I've got two. One is we have been called many times and I'm sure others may have had this happen, list agencies asking us to go over to their initial holding centers to assist a patient in giving -- getting their own medications, to make sure it's the right med and this and that. We said that -- no. If you want the patient to go to the hospital, that's great. We can't tell anymore than you can if this is the right bottle with the right thing in it. And sort of I think it may end up a practice issue. But is there any position from this body on that that we can send to our local police chief to that end?

DR. MURPHY: Well, I don't think that is within your scope of practice, you can't be doing that.

MR. LAMARCA: We also get it on routine

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Proceedings

calls, on occasion a call to a home and caregiver can't give a medication so wants you to try and give a medication that has been prescribed for patient. And, again, we are saying it's not part of the protocols, we are not to be called out to administer meds like that. And we had schools as well. When a child is in school and maybe there is a medication involved that the school nurse is not able to give so we always treat it as beyond the scope of practice.

DR. PAPISH: That's -- I mean, it makes obvious sense. I'm sure you guys would know the medicine and be like, it's probably fine. But really should you be doing that? It just exposes you to liability. And I think that if the patient or prisoner needs to take his medicine, you know, give him the bottle and if he happens to overdose then they can call you, but what are the odds?

MR. VIOLANTE: We will wait outside a little while --

DR. BERKOWITZ: But for the person in the home they have a doctor, they should call

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Proceedings

the doctor. This is not your job --

MR. VIOLANTE: Yeah, this is before that person actually gets to a facility, at a police station so there isn't a medical person there per se.

DR. PAPISH: He is talking about the patient at home --

(Everyone is speaking at once.)

DR. BERKOWITZ: Again, I think that is the point. You start doing it in the holding pen and all of sudden you are doing it at people's homes and in the schools and that's outside your skill --

DR. PAPISH: We wouldn't have jobs.

MR. VIOLANTE: I concur, thank you.

DR. MURPHY: What we could do is maybe -- do you find it's the police mainly calling you?

MR. VIOLANTE: For us, yes. Andy is a little bit of different situation for his group.

DR. MURPHY: Because we can put out a [ reminder letter to police agencies from the body itself just to say, you know, this is

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Proceedings

not part of the prehospital scope of practice of our providers, that is not a problem, just to remind people. However, you know, the home thing, just like Dr. Berkowitz said, you should refer them back to their PCP. Why are they calling you --

(Everyone is speaking at once.)

DR. MURPHY: They have to speak to somebody and they don't need to go in the emergency department for that -- let me just put that out there too.

(Everyone is speaking at once.)

DR. MURPHY: Don't listen to what he just said. And the second thing?

MR. VIOLANTE: Is after going through the CPAP process at the BLS level one of the things that we thought of and realized -- and there is some literature out there, which Dr. Arshad can speak to more than I can -- the use of PEEP for intubated patients and whether there is any provision for the use of PEEP, PEEP valves, etc., on an endotracheal tube for intubated patients?

DR. MURPHY: Yeah, there was discussion

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Proceedings

back and forth because there is some that are advocating it and some that are not, the little devices. You know, California put them out on every ambulance for a while, that was a few years ago. I brought it to here way back then. But it was pulled because they just didn't find the data that supported it and was it something that was helpful and so they pulled it.

But I can't remember -- we were just discussing this. I don't remember where. And so it was still -- oh, I know where it was, it was at my CMA -- so it was still kind of controversial whether it was something to be supported or not. I think the little devices are still out there, American Heart included it in their latest revision of materials. So I guess the device is still there. I don't know if somebody wants to add that into protocol, we could definitely put it forth and have the committee look at it and have everybody review and see what the research is out there and are the studies yea or nay? We could put it towards the

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Proceedings

collaborative committee. I'll give you the e-mail to send it.

MR. VIOLANTE: Okay.

DR. ARSHAD: So if folks have PEEP valves now are they allowed to use them?

DR. MURPHY: It's not in our protocols, but, you know, it's a thing where, you know, it's not one of those things anyone ever said they couldn't use. You know what I mean? It's the gray area --

(Everyone is speaking at once.)

DR. MURPHY: It had big, you know, auspices. When it first came out people were like, this makes total sense and the ICU guys were really on board for it and pushing and pushing and that's how it got into California and they widespread used it and it kind of backed off.

DR. ARSHAD: The data is really good now --

MR. VIOLANTE: For it?

DR. ARSHAD: For it -- except in cardiac arrest, with that caveat. So for the majority of dyspnea cases a little bit of

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Proceedings

positive and exploratory pressure is going to significantly help that patient, whether COPD or heart fail.

DR. MURPHY: Heart failure, the main one.

DR. ARSHAD: I'm a big advocate. And prior to us moving towards the BLS CPAP you could in fact, create BLS -- rather CPAP at the BLS scope of practice with the nasal cannula and 15 liters per minute as well as a BVM with the PEEP valve --

(The speaker cannot be heard.)

DR. ARSHAD: -- basically the data is pretty good except for in cardiac arrest where I just had a little update from the Eagles conference, sort of the state of the science. A lot of talk now an intrathoracic pressure regulation, IPR, as well as ITD and ACD data --

(The speaker cannot be heard.)

DR. ARSHAD: So I had the opportunity to meet Dr. Laurin (phonetic), visit his pig lab in Minneapolis, and they are doing tremendous research on cardiac arrest. And this concept

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Proceedings  
of positive pressure and negative  
intrathoracic pressure is confusing even at  
the physician level. But in cardiac arrest  
what they are showing is by blocking the  
passive expansion of the lungs during the  
cardiac arrest cycle it generates negative  
intrathoracic pressure, which increases the  
amount of blood returning to the heart or  
preload, which subsequently leads to  
increased cardiac output as well as increase  
coronary --

DR. MURPHY: With every CPR?

DR. ARSHAD: With CPR using the IT ACD.

A very interesting --

DR. MURPHY: So it's bringing more blood  
so you have more blood to utilize when you do  
your high --

(Everyone is speaking at once.)

DR. ARSHAD: Yes, understanding the high  
performance CPRs, it improves outcome.  
However, a very interesting New England  
Journal study that came out in 2015 was  
randomized double blind placebo controlled  
showed no benefit in outcomes. And the post



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Proceedings

talk analysis went back and looked at the quality of CPR, so they found that there was a lot of variability in the quality of CPR, compressions were not done uniformly, depth was not done uniformly. And people -- recoil is very difficult to teach. What does it mean to have effective recoil? And we notice that had doing high performance CME, people don't understand what recoil is, we have to teach them and show them.

DR. MURPHY: Well, that hockey puck thing, device really, I think, helps control --

(Everyone is speaking at once.)

DR. MURPHY: -- understand, oh, that is when I let off the chest.

DR. ARSHAD: -- so you have to let off the chest and not lean.

So with high performance CPR there is improvement in outcomes. However, if your quality of CPR is questionable to begin with it actually has increased mortality --

DR. MURPHY: Yeah, a negative outcome.

DR. ARSHAD: Also, just updates from

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Proceedings

Eagles. A lot along those lines, heads up CPR with mechanical compression devices can, in fact, preserve neurological function if you obtain ROSC.

And then also a lot they discussed on comprehensive stroke centers and the whole intervention of clot retrieval.

DR. MURPHY: Intervention of clot is really going --

DR. ARSHAD: For stroke. So the two also randomized double blind placebos on --

(Everyone is speaking at once.)

DR. ARSHAD: -- in 2015. So significant improvement in outcomes up to 12 hours when patients are outside the TPA window to actually go in and get the clot.

DR. MURPHY: Interesting. But doesn't the gentleman at Westchester do that?

DR. BERKOWITZ: Yes.

DR. MURPHY: What is his name?

DR. BERKOWITZ: Steve or Mike?

DR. MURPHY: Yes. He is amazing --

DR. BERKOWITZ: Yeah. His program actually was very similar to the program --

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Proceedings

you know, I give him a lot of credit for as much as he gives trouble to people, he pushes hard on getting what he wants done. The realty is that his program of using aspect scores, using NH cut off, and using CTA to guide decisions to treat he actually ended up being the -- what the evidence is. And it's kind of cool to see how it all played out because there are other centers I know that were doing kind of anyone. And they bring people in, put them in the lab, give them CPA --

(The speaker cannot be heard.)

DR. BERKOWITZ: -- and everybody go and say good job and the patient would have the same outcome, if not worse. And he was very insistent in having criteria, which ended up being very close, if not essentially the same, as the Mr. Clean study. So I think it's pretty cool to see how it's progressed.

DR. ARSHAD: We do interventional clot retrieval at Vassar are there any other --

DR. PAPISH: Mid-Hudson have seen guys come up.

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Proceedings

DR. BERKOWITZ: So it's the same program, the same criteria, everything is kind of the same.

The other thing is there is discussion at the State level to comprehensive legalization -- because I've looked at this data so many times on the stroke stuff, the time it takes to transfer is very long. And I actually did analysis of our patients to see, gee, does it make a difference if the patient comes in and you know off the bat they have a stroke, they have high NAH and you can't give TPA. If you think, gee, that's going to be a patient who's going to get called right away and still people are waiting the hour. The AHA stroke clock is an hour, right? So people are waiting the hour and then they call it. It's -- you know, it's going to end up being we have to regionalize it.

DR. VANROEKENS: I would want to add to both the stroke -- comprehensive stroke and getting patients out and also trauma we need to know what our secondary times are once

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Proceedings

they present to one of the outlying smaller hospitals. I can tell you with Trans Care gone, with the limited number of services it stinks, it's not good. Okay? Even if you see them right when they present you can call it and I've done this a number of times, this is for trauma, this is for stroke. I think we need to try and look at that and maybe STAC can kind of -- RTAC can give a report of some of the secondary times, again, blinded by hospital, but I think it's important for us is to know what the EMS interfacility can do. Again, you know, I think they do a great job with what they have, but I don't think it's where it should be for people who live in this area.

DR. PAPISH: So probably enhanced role for helicopters.

DR. VANROEKENS: When they can fly.

DR. PAPISH: We use them for trauma all the time, but I imagine we use them less frequently for acute medical issues that do --

DR. STUHMILLER: Yeah. It's a resource

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Proceedings

and you can call and see if it's available.  
I mean, especially anything vascular you can  
make the argument the most time sensitive  
conditions out there whether --

DR. MURPHY: Like the --

DR. STUHMILLER: -- stroke or  
hemorrhage --

(Everyone is speaking at once.)

DR. STUHMILLER: -- rupturing, a spleen  
that is hemorrhaging that there is not an  
ability at the hospital. Anything vascular  
you can make the time argument for using the  
fastest transport vehicle.

But we also have quite capable critical  
care providers with paramedics and nurses  
that are cross trained and interchangeable.  
We hold them to a pretty high level of  
clinical care and quality around that care  
and so we also do have quite a lot of  
medications and monitoring devices and we use  
-- we use PEEP valves when we have to bag  
someone and entitled Co2 on ventilation rate  
during bag if mask is appropriate. And then  
we have a transport ventilator, of course,

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Proceedings

that we put on immediately upon arrival to the aircraft, or bring it to the patient if we know they are already being ventilated. So we think the clinical care is just as important that we provide on the aircraft. But for vascular issues you can make the argument that giving the person the fastest way to their destination is more important maybe then some of the care delivered.

MR. VIOLANTE: I think this is vastly important for prehospital providers to have some tremendous education on this. And I say that because it was a huge foundational change for us to move away from --

(The speaker cannot be heard.)

MR. VIOLANTE: -- to say no, don't throw him in the ambulance and go to the local hospital, wait 15, 20 minutes here for a helicopter or drive further to the place where they need to go. It's going to be tough for a lot of people to do that. And we are going to have to do a good job with that education, especially if we're saying trauma center here is the right designation, cardiac

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Proceedings

center, here is the right designation and you know, it's a huge challenge, I think.

DR. MURPHY: Dr. Mao?

DR. MAO: There is also another one that falls on the providers and going into the training programs where ASTL is not advance trauma life support, it's advanced telephone life support. It's worked well at Westchester. They will take patients, hi, this patient, no bloods, nothing, accept the transfer, begin the process, do what we have to, ship and go. A lot of providers that I know, oh, no, I have to get him stabilized before I call so and so. It's not because they won't take them, Westchester will. A lot of providers they are used to working in facilities with residents. I get them to us, that is to a trauma center where they train, they never transfer them out. So they are stuck in this mode, I'm going to work them up in a smaller facility that don't have that, clearly are not going to do it --

(The speaker cannot be understood.)

DR. MAO: -- and meet them together.



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Proceedings

There is a big push for our providers from the physicians, from PAs and mid-levels is telephone life support. Great, call the helicopter, get the ground crews ready, we have to do that. There is a big push on the provider side, look, get them out. We have backup from the transfer center -- at least in Westchester where I call -- they say fine, not a problem, do it. I think that's where we get the biggest bang for our buck quickly in getting --

DR. BERKOWITZ: It takes 30 minutes on average to get an ambulance from the point the transfer center says, okay, they are accepting all that. And so you can just call an ambulance whenever you want. You can -- a lot of you guys have your own contract, a lot of transfers they call and say, hey -- and then transfer center says you want us to arrange transport? Usually the ER says no, we will take it care it and we have our own people. You can call that before they get to -- before they get there, expect it will be 20, 40 minutes before you get an ambulance

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Proceedings

there. The ambulance are not going to -- it will help those critical patients getting them out the door. And we have a lot of process to allow for auto dispatch of our own ambulances. I know the helicopters are auto dispatch as well. If you call the transfer center and say, I need a helicopter here. They are not going to wait until -- until you have the doctor on conference, the same thing with our peds critical care team. They'll be out the door before you have even send with the assumption that you are an ER, you are saying this is critical, we are going to get this done.

DR. MAO: So out of the smaller hospitals, one is calling for the ambulance, they want an accepting physician, you can be delayed transferring to facilities, New York City, not to pick on them, but they can't push off. Again, Westchester I give you kudos because they are accepting physician and you go. And then transports will authorize and bring the crews in, they are not far away so speeding up the process could

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Proceedings

be auto acceptance or rapid acceptance and getting the crews involved --

(The speaker cannot be heard.)

DR. VANROEKENS: Having worked at many of the hospitals in this region, I can tell you that it depends upon which hospital you are at how quickly EMS can respond to interfacility transports. And to think that it could happen as fast as it should, we are deluding ourselves. I think it would be helpful to track some of the numbers. I think it's something we need to look at on a regular basis to get patients to the right place --

DR. STUHMILLER: It's a continuous argument in the air medical circles as to whether or not patients should be brought primarily to the designation or brought and transferred subsequently. And what is missing from that argument is just what you said, the data. And you think about trauma we have had the mentality that trauma patients belong in trauma centers for decades and just within the last year has the

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Proceedings

regional trauma entity gone to measure how long that takes. You'd think if we all agree and have the idea that trauma patients belong in trauma centers, we had no idea how long it takes, if it takes five to seven hours to transfer a child and four to six to transfer an adult that is a patient that needs to be in a trauma center and that takes that long. So for stroke we can make the same analysis, how long does it take to get a patient to comprehensive stroke center when it's determined that the patient would benefit from that?

Now, one of the things that we haven't talked about is what is the EMS decision? And one of the disappointments that I had when the State came out with stroke guidance a few years ago is, if the patient can get to the stroke center within two hours of symptom onset, you get them there. That was it. It had nothing to do whether or not they could get TPA, they couldn't get TPA. And what if it was longer? And there was science on whether it was longer. So it does not really

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Proceedings

take a lot of effort to go through the TPA checklist and find an eligible criteria and say, maybe I shouldn't go there, maybe we go to the comprehensive center. So that would be the first step from the very start, EMS evaluation, does this patient belong in a primary stroke center -- to use an American Stroke Association term -- or do they belong in comprehensive stroke center? That's step one.

And step two is having the emergency department in the hospital 's culture be one that is able to admit, I can't take care of this person here and this person needs to go somewhere else.

And then the third step is having a defined transfer arrangement with the receiving center so you don't have to wait for the workup, or the blood tests, or the physician to get on the phone. It's just that we already have this figured out for these types of patients so I think it would be a little different for trauma, for cardiac, STEMIs, specifically for stroke,

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Proceedings

again, vascular issues that we ought to be a little more coordinated. And then you use whatever transport resource is available. If it's a helicopter because it's fast and they are available, that's great, but we are not always going to be available in the air. Today, fine, you know. Tomorrow, maybe not. And so that would mean there would have to be another system for ground transport equally efficient or approaching such time efficiencies as you can get by helicopter.

But we are a long way away if we only started to collect and analyze the trauma system in our area. That would be something the region could take a lead on for other diagnoses, pick something that everyone agrees upon, it's important to get to a particular hospital. That way you might have invite some of the hospital political issues and some of the health system directives to go to certain hospital issues.

MR. VIOLANTE: We used to have a TPA checklist many years ago until the State came out with the idea of generalization for

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Proceedings

stroke accepts, for the time window. I think the only other option is before they even get to the hospital, is the agency going to allow this one ambulance, of which there are only two in an area, to leave for an extended time because they are bringing the patient, but maybe not from the area so that is something to add to --

DR. BERKOWITZ: That is always the underlying issue that, you know, you are leaving your municipality uncovered. And that is a tough call that we feel like the State should come in and help find ways that resources can be fairly shared and used because in the end the transports happen. So you know --

DR. MURPHY: It's just delayed --

DR. VAN ROEKENS: --it's four hours later.

DR. BERKOWITZ: Exactly. And it actually takes more time. When I looked at especially the stroke ones I have seen it's -- you know, not only you have the time for another dispatcher to get involved, to go

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Proceedings

through intake with them, to book the call with them, for another team to come, assess the patient, repackage the patient, this is all wasted stuff. It's all wasted stuff. And then this is all happening to get the patient -- you know, get the patient four hours later when in effect sometimes the extra drive would have been 20 to 30 minutes most call times in Westchester --

DR. VANROEKENS: Westchester, it's probably true. Hudson Valley, maybe not much --

DR. BERKOWITZ: Not that much, but there is still a lot of the time is spent on not driving the patient.

And the one thing I want to say about the stroke stuff is that, you know, the Mr. Clean study and studies out there looked at patients with TPA and then got endo. And I think that as the data comes out we are going to end up having to make calls on patients who are TPA candidates, still bypassing to get endo because the impact from that high NAH, or whatever score you want to



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Proceedings

use, you know, the likelihood of TPA working is so low they are just to soften the clot. It's so low that you are still going to want to say, bypass and go to the CSC. Because otherwise the delay is pretty significant and the benefit, if you look at the delay benefit for TPA versus endo, the studies out there, it's two or three to one in terms of the EOR, again, for those sicker patients.

DR. MAO: I think advance telephone life support, if the crews are 15 minutes out they get a heads up, for example, to Westchester and another local facility has heads up, look local crews coming in, we are sending out a crew, can you accelerate interhospital transfer, local interhospital transport crews are in and they ship them right out as long as there is clearance --

MR. VIOLANTE: It's possible to do that in the field. To be honest, we have done it for nonemergent cases, we don't leave the district we --

(The speaker cannot be heard.)

DR. MAO: Potentially the crews is

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Proceedings

uncertain and they want to get medical -- they want a quick evaluation, it requires the crews, interhospital, both hospitals being on the ball and people saying fine, you are coming in? I call someone else or Westchester calling, hey, we are approved, your crew set them up and we take them, we will go. It's a change in culture on all sides. The system is there.

I also agree, you are right, you don't want to have the BLS crews pulling out -- they are tired, they don't want to drive that much further at 3:00 o'clock in the morning. The interhospital crews are there, ready to go. It's a change of culture, the system is there we have to change how to manage it.

(Everyone is speaking at once.)

DR. MAO: Peds, auto acceptance --

DR. MURPHY: I think people need to realize they don't have to be uncomfortable not getting the CAT scan. They are going to scan them down there anyways. So if you can determine the person needs to be at that center, just launch.

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Proceedings

DR. MAO: It's simple, we are not going to admit a peds at our facility anyway. We need to push out to help providers feel comfortable and the medics and BLS crews and this system will gain a lot of time very quickly. Before we get the data, let's jump ahead --

DR. WILSON: Did you compare times between stroke MI and trauma?

DR. BERKOWITZ: So I mean I have -- I don't have any -- the extensive data, the best I have is on stroke --

(The speaker cannot be understood.)

DR. BERKOWITZ: -- in terms of all the time stamps. I know that the -- definitely stroke is faster than trauma because of the --

DR. WILSON: The workup --

DR. BERKOWITZ: -- the workup is so much more extensive. But if you take a look at high ISS trauma, you end up getting faster times, if that makes sense.

DR. WILSON: To Dennis's point, I would just like to say, I think you know, that

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Proceedings

cultural change that happened with STEMIs, remember we used to give -- you know, the hospital like mine is people that -- it's very small, we don't have cath lab, we don't have neuro IR, but my God we are good at getting patients with STEMI out within 20 minutes, out in the ambulance on the way to a cath lab. I think that same cultural needs to be changed with stoke now because all these time windows of three to four point five hours which may -- maybe qualified, maybe not. I think what they are moving towards is more profusion images instead of timeframes for a detached endo, you know, for neuro IR. And I think we are going to see that same philosophy applied for EMS where you are right, there is going to be a comprehensive or a local stroke center and does this person really need the comprehensive versus local based on time. But the profusion imaging is that one thing that is really driving us whether we call -- we call like a STEMI at our facility for now strokes, it's the same kind of rapid lights

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Proceedings

and sirens response to get the strokes down to Vassar for neuro IR if that patient meets that profusion image criteria. So it's going to change. I'll tell you we will sit here five years from now and I bet it will be a lot different.

(Everyone is speaking at once.)

DR. MURPHY: Craig, there is -- they did mention at SEMAC and I received an e-mail, but I did not look at it, maybe you have, STAC just put out a huge data collection report, so I don't know if that material is in there. I have not looked at it, but they were definitely commended on the comprehensive nature of it and that they had a lot of data.

DR. BERKOWITZ: I haven't seen it --

DR. ARSHAD: I e-mailed you the link from the last SEMAC, maybe if we include the link on the collaborative protocols we send out too.

DR. MURPHY: Sure. Yeah. There is supposedly a great deal of information in there from what they have collected over the

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Proceedings

years.

All right, good stuff.

Any further -- was that it for Dave?

MR. VIOLANTE: Oh, no.

DR. PAPISH: I know it's late, but I just wanted to ask one thing. I don't know if this is something that needed to be voted on. We were discussing just in general CME and how we -- you know, one of the things that has come up, even though we all do CME at our various hospitals for prehospital providers, there is never enough and they are always looking for more. We live in an age where we can webinar things very easily and pretty easily verify over the web that the people are there because we have two-way camera and so it's pretty easy to prevent fraud, which is a big thing everybody who worries about, you have a webinar, nobody on the other end, everybody is signed in, but they are all playing golf. You can prevent that by saying, look there is people there, the sign in sheet is valid, and do attendance roster on-line.

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Proceedings

Would it make sense at this point to jump on the tech knowledge whenever we have webinars and whenever we have CME events, whatever they maybe, if the facilities are capable or want to, they can setup cameras, have a two-way event and have a remote site so that another squad 45 minutes away doesn't have to drive in to come to the webinar and increase the attendance and educational value of the stuff we are doing.

Is there -- we don't have a rule about that other than we sort of in the discussion said there has to be a way it has to be interactive two-way so that those providers could ask questions during it and --

DR. MURPHY: Yeah. You could do it in many modalities of having it be an interactive session or at that remote site you have another doc, just a doc to be in the room if you can get enough attendance that it's worthwhile and you can have remote site of the same information. I think that a lot of stuff is being done. I think it's kind of a communication issue too of when we

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Proceedings

publicize it, when we get the word out there.

You know, we recently did a few CMEs, this pit crew CPR, over at Laerdal. And they are wide open, anyone can use their facility, it's crazy what they have at that facility, their equipment -- equipment is outstanding. And they -- you know, they've walked up to me as we are in the middle of a fire drill outside freezing, they hand me a card, if anybody wants to use it at any time they can set it up with them from any region. It doesn't have to be like Dutchess that we did that time, it could be anyone. So it's a thing where there is a lot of opportunity out there. But I think providing CME and education is our responsibility and that we have to do it.

I see something over here, do you have a new education coming up?

DR. VOHRA: No. This is something I picked up on the way in.

DR. MURPHY: Isn't that the front line conference?

DR. LARSEN: Friday, April 1st --



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Proceedings

DR. MURPHY: April Fools Day?

DR. LARSEN: That's correct.

DR. MURPHY: All right --

MR. LAMARCA: No comment.

DR. MURPHY: Orange County Front Line conference will be April 1st --

MR. STONICK: It's a two part conference --

DR. MURPHY: Oh, first and the second, yeah. Tell us a little bit about it.

MR. STONICK: It's the typical annual conference for EMS Council, it's a still session on rapid extraction and a lecture pretty much all day on Saturday. Several of the doctors here have spoken at it in the past, including Dr. Arshad, I think Dr. Murphy, you have spoken there a couple times. It's coming up fast, it's been out for a while. I believe it's on the website, just a matter of continuing to get it out and communicate to the people out there.

DR. MURPHY: Yeah, there is somebody doing a key note, tell us.

DR. ARSHAD: Well, Dr. Papish set me up

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Proceedings

there, it's riding the foam ED wave, social media in EMS and we will be live-streaming that.

DR. PAPISH: So is there any need for any kind of vote or do we --

DR. MAO: Before you do this you should talk about the CICs in the State. They have some rules about verification for the CICs because they have to sign someone is actually there, if you have a hundred people signed up they have to verify that.

DR. PAPISH: That's what -- I mean, we could have remote attendance. It's pretty easy if there is a camera and there is an attendance roster.

DR. MAO: You have to verify a hundred people potentially on the other side of the video camera, but vote on it, but talk with someone from CIC first.

MR. LAMARCA: I think we get into the fundamental differences between CIC and --

DR. MURPHY: Yeah, that's another thing --

MR. LAMARCA: Medical control contact, I

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Proceedings

think is what we --

DR. PAPISH: That's easy --

MR. LAMARCA: We do have issues as far as core content for CME refresher and what it has to meet. I have been approached at certain meetings for people to sign off and I won't depending what is going on. So you are right, there are nuances I think with the medical control -- go ahead.

MR. STUHMILLER: The way to get around that is have the CIC present in the room with the group watching and, therefore, that individual can with good conscience appropriately sign off on the people in the room.

(Everyone is speaking at once.)

DR. MURPHY: I think one of the things that -- Karen is being very quiet in the back of the room and not commenting during this discussion -- but we need to make sure people approve ahead of time, the content is there and quality of the lecture is there, the significant nature of it. Is it for the prehospital audience and what we are trying

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Proceedings

to do. So that's the only other thing to try and present it, it's given, it's recognition and worth --

MR. VIOLANTE: Even if it's recorded, period. Then can be played back, you know, at another time even if it's just CME. There is amazing stuff happening out there that we are missing and not capturing that should be recorded for future --

MR. HUGHES: Just so everybody knows, there is two separate things we are talking about and we are intermixing them.

There is the medical contact hours -- medical control contact hours, which are the physicians in the REMAC that have to teach the providers, or have lectures with the providers that work with the region to recertify them as MAC paramedics out in our region.

And then there is a CME program, which is the State program, which involves the CICs. So when we -- in the region we require medical control contact hours for the providers to recertify. And in the State

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Proceedings

they require the CMEs. So sometimes they can be used interchangeably with the physicians doing the medical control contact hours, but the CMEs where there is only CIC that is there it can't be used on the medical control contact hours. They have to be a MAC approved either physician, nurse practitioner or PA. Just so that we -- there is two different things, we interchange them all the time, but we really need to know what we are discussing.

DR. PAPISH: Can we make a motion then with regards to the medical control contact hours, we would be open to allowing the future medical control contact hour CME courses and lectures to be available, if they are available via webinar, to remote sites as long as attendance can be verified, that the remote sites could be able to obtain medical control contact hour credit for those sessions.

MR. HUGHES: The only addition is it has to be interaction.

DR. PAPISH: And that it is interactive.

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Proceedings

MR. LAMARCA: It wouldn't be able to be reused as a tape.

DR. MURPHY: Right, it would be the live course --

DR. ARSHAD: Nevertheless with the tape what if you have survey monkey and questions afterwards, does that make it interactive?

MR. VIOLANTE: No.

MR. CRUTCHER: No.

DR. MURPHY: Because it's not real time for the way it's setup for CME in the past.

So that's a motion on the table. Any seconds?

DR. BERKOWITZ: Second.

DR. MURPHY: All those in favor?

So it is unanimous again.

Okay, any other --

DR. ARSHAD: I'm going to sneak in a last issue because it's important. So I hangout with a lot of paramedics and I recently got involved with the group called the EMS Wolf Pack and I bring this up because mental health in EMS a significant issue and one that we don't talk about often enough.

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Proceedings

And within our small group we recently with one degree of separation had two MOS suicides. And that's the sort of thing where as a medical director you hear that and it just sort of rocks your socks and you are taken aback and you're like, oh, my gosh. What is going on here?

So just to share some statistics. The rate of PTSD in first responders is 30 to 40 percent over a career lifetime with the general population being three percent. The suicide rate among first responders is -- EMS first responders is higher than both fire and police and significantly higher than the general population.

So it is an issue that we need to bring significant light to and just start talking about more. I think just talking about some of these things is really eye-opening and just helps people cognitively off-load and things along those lines.

I'm going to be doing CME in the future, but we just recorded a pod cast for the services out there. If you guys -- just to

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Proceedings

get the word out there is a great organization called a Code Green campaign and actually based in Spokane, Washington, operating throughout the country. They have tremendous resources, everything is completely free, but crisis counseling as well as in the State of Alabama and in this particular country and you go on the website they have a provider -- a reference for provider that has some specific training or skill set with responders. So just to sort of say this real, we don't talk about it enough. The type of work that all our guys are doing boots on the ground is stressful, seeing things on a daily basis which is horrifying and as medical directors we don't talk about it enough. Let's just bring light to the issue. And if there are folks struggling, get them help they need and start talking about this in a nonjudgmental nonpunitive constructive manner.

DR. MURPHY: Is that an acronym for something?

DR. ARSHAD: EMS, Wolf Pack, it's a



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Proceedings

movie --

DR. GUTMAN: Of some people --  
disfunctional people locked in an  
apartment --

(Everyone is speaking at once.)

DR. GUTMAN: Just saying, I don't --

DR. MURPHY: Did you just Google it --  
I'm kidding.

DR. GUTMAN: Weird knowledge base.

(Everyone is speaking at once.)

DR. ARSHAD: It's a group of paramedics  
from Australia actually that were trying to  
band together to create resources so they  
could travel to conferences together, that's  
how it originally got started.

DR. MURPHY: I haven't heard of it.

Anything else?

A motion to --

DR. MAO: Motion to adjourn.

DR. MURPHY: Second?

DR. PAPISH: Second.

DR. MURPHY: Thank you everyone for  
coming.

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

  
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Yvette Arnold

