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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, June 6, 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. MARK PAPISH,
Medical Director

DR. DAVID STUHLMILLER,
Helicopter Subcommittee Chair

DR. ARSHAD,
Evaluation Subcommittee Chair

WILLIAM HUGHES, EMT
HVREMSCO Executive Director

KAREN DELAUNAY,
OFFICE MANAGER

JEFFREY CRUTCHER,
QI Coordinator

GOOD SAMARITAN HOSPITAL

DR. DENNIS MAO, (via telephone)
Director

NYACK HOSPITAL

DR. WILLIAM GREENHUT,
Physician Representative

ORANGE REGIONAL MEDICAL CENTER

DR. ROSE ANNA ROANTREE,
Physician Representative

PUTNAM HOSPITAL CENTER

DR. BUTTERFASS,
Director

MID HUDSON REGIONAL HOSPITAL OF WMC

DR. PAPISH,
Director

DR. BERKOWITZ,
Physician Representative

ST. LUKES CORNWALL HOSPITAL

DR. SCOTT HILL,
Director

VASSAR BROTHERS MEDICAL CENTER

DR. ARSHAD,
Physician Representative

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

MIKE BENENATI
RICHARD PARRISH
ISRAEL KNOBLOCH
ANDY LAMARCA
TIM MURPHY
JOHN MAHONEY
DAVE GRASS
BEN ZABAR
JOE SOLVA
JIM HUTCHISON

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DR. MURPHY: Okay, we have a quorum so I'll bring the meeting to order. Thank you all for coming.

The first thing on the docket will be the review of the minutes and acceptance if everyone is capable. We have one correction, we made one typo with a person's name. We just need to change it to their name, instead of Maryland.

Otherwise, do I have a motion to accept the minutes?

DR. ARSHAD: Motion to accept the minutes.

DR. MURPHY: Thank you, Dr. Arshad.

MR. BENENATI: I told you to sit him there --

DR. ARSHAD: I worked overnight so I maybe --

DR. MURPHY: You look pretty good for working overnight.

Okay. Under old business we have a -- things that are old from the last meeting.

There was a notification of, you know, about BVAC. We had talked about that many

many times over the phone and over different entities. And there is a few notifications about Regional EMS and duplicate notifications coming up. Neither here nor there, it's all kind of in order, but nothing more to announce, it's really all old stuff since the last meeting.

Service upgrades, we have none for this time.

Evaluation subcommittee report, Dr. Arshad.

DR. ARSHAD: We will get into the Beacon thing --

DR. MURPHY: Yeah, you can talk about it now.

Well, basically what had happened was we had a problem with coverage with being available with there being problems inside the organization with diversion, problems with interaction involved, let's say the staff, I don't know -- would that be the best way to put it?

DR. ARSHAD: Appropriate.

DR. MURPHY: Without going into tons of

details, but you know, it was related to the Department of Health, who came forward to us, brought us forward all the information and we met and talked about it and had many phone calls back and forth. But as of that time BVAC had to reduce its coverage to basic life support and no longer provide advanced life support. And that happened back in April, which was a while ago. So the areas covered by BVAC were taken up and thanks to other agencies -- and notably, Mobile Life in the area -- we have been able to keep coverage going and not have any lack of care for the people in the Beacon area per se.

The ALS -- they went on to explain why they -- you know, it happened and such. But it was effective April 1st. And they now have a support agreement with Mobile Life to cover wherever they need to do with ALS in that community.

Do you want to add anything else?

DR. ARSHAD: No.

DR. MURPHY: That was the main part of our biggest actions from evaluation

committee.

DR. ARSHAD: And then one other issue was, we did a required review, ALS review, from what LaGrange Fire -- thanks, Mike, for sending that in -- the crew provided excellent ALS care. We mention this because it's a pleasure to work with you Mike. I just wanted to recognize you for your compliance and diligence, you make it fun. And excellent ALS care provided by the crew. I know that's a standard that LaGrange takes very seriously.

MR. BENENATI: Thank you.

DR. MURPHY: Helicopter Committee report. David is not here, right?

Did they have a meeting? Did anyone meet? I don't know.

We will put that on hold just in case.

RTAC, Dr. Berkowitz?

DR. BERKOWITZ: Actually, we were both there.

DR. MURPHY: Yes.

DR. BERKOWITZ: So you know, it was basically the protocols, voted on the

protocols. And that's pretty much all I remember. I was kind of on my phone a lot of the time.

DR. MURPHY: No problem.

So basically I have an announcement under that aspect. The State granted --

DR. BERKOWITZ: Oh, I was thinking of SEMAC. I was totally at the lunch, I apologize --

DR. MURPHY: No, RTAC.

DR. BERKOWITZ: SEMAC, I was at the lunch, I apologize.

Most of the discussion revolved around reviewing the data of transfers, trying to improve the time it takes patients to get definitive care. So we have been doing that at every RTAC. There was a discussion telemedicine, a discussion of the utility of prehospital telemedicine, as well as telemedicine from other hospitals.

I think that there is some, you know, some -- you know, healthy resistance, reluctance, or, you know, concerns about the ability to do telemedicine from a prehospital

setting and the greater ease that there is to do it at a referring hospital. And there has been some discussions after the fact with the Air Methods platform. And I believe they were talking to Mobile Life, as well as Empress in Westchester County, to talk about to see if, you know, if there would be an interest in utilizing their platform for prehospital telemedicine, if we can find a way to make it work.

So there is probably more to come on that although I think that a lot of -- some -- like I said some of the people had thoughts that it might be hard to do telemedicine from a prehospital setting with the available infrastructure.

DR. MURPHY: And then there was -- you guys were talking about the peds disposition issue too, right? Was that this meeting or the meeting before --

DR. BERKOWITZ: So there was a couple of things that came up on the peds side. One is whether the patients who don't -- who are at non pediatric hospitals who don't need --

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there is a discussion about whether they need pediatric care. And this is something that -- I think that we need to work on to support us. The goal should be to prevent unavoidable transfers. And I think that in general I would say any community hospital that wants to transfer a potential pediatric trauma, I think that's reasonable. But I think that we need to find a way, what is the approach that -- you know, a level two or non pediatric center, what -- should they be transferring every child as well? This is an issue that is coming up that I think we haven't really resolved yet. And I think that we do -- because I think there is the risk for some unnecessary transfers, which is obviously a drain on the system.

DR. MURPHY: And also the parents get pretty upset too. That's the other thing from a logistical point of view. I find that the families, if they go down and get discharged, which is fine, they get evaluated, they are at a trauma center, it's a level one trama center, they kind of have

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an issue about it. And yet I guess they don't see the big picture, when the kid falls into the field triage criteria for trauma, what do you do? So I think we have to workout a solution there. I agree, I don't think there is one answer. It's going to be have to be something we look at. But, you know, the falls especially, things like that that are -- where really a kid, you know, that still looks pretty good and yet traumatically had a kinematic injury that falls under that criteria at level one trauma center is difficult. And I think it's difficult for providers too because they are kind of caught in the middle. But I think most of us will agree a really traumatized child belongs at a level one center or pediatric center, that's kind of a no-brainer. It's the ones that are minor --

DR. PAPISH: -- criteria.

DR. BERKOWITZ: I think that the PECARN guidelines are really good. And I think that if all the docs are following those I think that that would probably save us a lot

of those questions, you know, of what to do certainly. And if you fall into the group of observation versus CAT scan on those guidelines, then that's a discussion to have with the family. With the understanding being if they get transferred they might get a CAT scan because that's kind of what the rules say, you either do a CAT scan or observe.

DR. MURPHY: Yeah.

DR. BERKOWITZ: So I think that -- I think that you know -- and those guidelines apply to the docs, not prehospital. So that's a doc thing. But that -- I mean, I just think that if we follow those more -- if you -- we really -- with the PECARN guidelines for head trauma it would make it easier. We are really talking about the kids with potential head injury who the discussion is whether they need to be imaged or observed.

DR. MURPHY: Andy?

MR. LAMARCA: You know, I think we need some sort of clarification for the field

providers. Just going with the BLS protocols again, in the 2011 guidelines if you take a look at pediatric in the middle class for falls, you know, less than 20 feet or children, 10 feet, high rate auto crash, there is a whole bunch of things in here for pediatrics we deal with on a daily basis. And the decision to transport, which is dependent upon the trauma system, need not be the highest level of trauma center so level two or three might be appropriate according to the protocol. Obviously, we are being told by a lot of level two and three they don't want the peds in there --

(The speaker cannot be heard.)

MR. LAMARCA: Yes, from the field, if we can we should go directly to level one if indeed the patient requires that. But until we clarify this, you know, it's still going to lead to secondary transport, go to the local and on that conversation too is pointed out some of the level two and threes are not doing what the level two and threes are supposedly categorized to do. So the field

provider can't help you make the right decision. Again, this is a lot of -- the area north it happens, BLS providers, ALS, a little less. Our system we can go direct to the medical center if we have to, BLS can't. This is looking like we are still continuing to dump pediatrics cases in the twos and threes that are going to stay there. And we want to avoid the six hour delay getting them to the trauma center or up north to Albany Med.

I know, Mike, we have had this discussion --

DR. BENNEK: Yeah. We have spoken about it and started some of the conversation since the last RTAC meeting and we talked about getting the protocol committee together and expanding it to include some additional folks. One of which is Dr. Dailey, who agreed from the STAC to be in on a phone conversation to start addressing some of these needs and then hopefully take it statewide. Because there is lots of confusion for the prehospital providers and

then certainly there were some EMTALA questions that have been asked and we just wanted to make sure we get those all addressed. And Dr. Stuhlmiller has agreed to be on that conference call as well. So Bill and I are going to work on over the next couple weeks getting that conference call scheduled so we can try to just get a TAG going to discuss this and see if we can move anyplace.

DR. MURPHY: Yeah, I think that the pediatric question is very difficult because it's not always cut and dried. But I think the worse case scenario for people for now is they go to the institution they feel is the correct location and if there is any question they go to the closest trauma center and let them evaluate the child and decide and move from there. You know, I think that there is going to be many questions that come up, many issues that change it one-way or the other. I know the EMTALA thing with the helicopter is really not an issue as long as you have it all setup and the agreement is there. So I

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think it's more a decision making process of where is the best destination for this child? And sometimes we -- like we talked about before with other cases going to Westchester, if need be we can see them and launch them, you know. And that's the thing of like discussion of with the trauma center, you know, I have this kid -- I think this kid, you know, has multitrauma and needs to be there and launch them and get them there sooner rather than later and don't waste a lot of time on anything other than --

DR. BERKOWITZ: So I think that -- I know that Air Methods will launch the helicopter if you call and say hey, I need a helicopter. They are not going to wait for acceptance they'll get -- and the same thing is true for us for when they are down and you want our critical ambulances to self-launch. In fact they are self-launching now in a way because they have more access to transfer calls so they can see what is going on. If they said, you may have noticed this --

(The speaker cannot be understood.)

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DR. BUTTERFASS: They show up.

DR. BERKOWITZ: They show up. They say oh, my -- they have a status epileptic at Putnam or something, they see it and say let's get in the car and go.

So that will help, but I think that the best thing is the --

(The speaker cannot be understood.)

DR. BERKOWITZ: -- and I think we definitely need help from the individual counties to make sure that when there is a really injured child that, you know, we are giving them the chance -- giving them if possible the chance to come down to the level one peds center as early as possible because that makes a big difference. And, you know, those cases are obviously very few, but are the ones that you don't want to miss.

The other ones where people go to level two and get evaluated and say, well, they have a fracture that an orthopedic certainly can't handle, most of that stuff although is not great for the system, it would be ideal if that child would have just come down

because it would have cost so much more time. You know, there is no -- at least there is no harm to the patient but there is still --

DR. PAPISH: -- it's not the end of the world. The reality is that obviously -- what we want is the sickest of the sick to not go, you know, somewhere before they have to go to definitive care. But all these other patients, I know the numbers are awful when you look at the times, six plus hours to get down, but how many of them are actually managed operatively, emergently, intraabdominal hemorrhages, most are managed with aggressive transfusions and ICU monitoring. So as long as we are getting the sickest of the sick children down, you know, we would be making an improvement in the system without too much added cost.

I think it is a good idea there has to be some sort of scoring system for the actual hospital, whether it's ISS to determine what, you know, just merits getting them down there.

MR. BERKOWITZ: The one thing is that,

you know, calling for a consult, which happens occasionally on a pediatric patient is reasonable. But the way our system is setup, you know, when you call us you usually talk to the peds ER doc, board certified peds ER doc. And that doesn't -- a lot of that sometimes is on the medical legal side and it doesn't really afford that much protection because, you know, the patient kind of belonged to the hospital in which campus they reside. So, you know, that call, although we are always happy to provide feedback and management, you know, advice, it doesn't -- medical legal side it doesn't do much, if anything.

DR. MURPHY: Dr. Stuhlmiller?

DR. STUHLMILLER: So the American College of Surgeons field triage of injured patients kind of implies that if you have one of the three physiologic criteria, or one of the subanatomic criteria you go to the highest center available. So they don't say that pediatric trauma has to go to pediatric trauma center, but that's kind of what that

implies. And that's kind of the way I understood the reading of those guidelines. If you have one of the many mechanism criteria then you aren't expected to go to the highest level trauma center so that would be reasonable to go to the closest trauma center available to the patient and let that center decide whether or not this patient needs to be transferred. And I don't see how that's any different from pediatrics in terms of mechanism criteria. And that's kind of the way I talk about this even though no one --

DR. MURPHY: Your interpretation.

DR. STUHLMILLER: That's how I interpret those guidelines. And that's kind of how I think it happens anyway -- or I hope it happens. That when a pediatric trauma patient arrives at a non pediatric center and they are, quote, really sick or really injured, I think that the really injured patient will manifest one of the three physiological --

DR. BERKOWITZ: I agree.

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DR. STUHLMILLER: -- is actually kind of how it goes.

And that said, John is right that Air Methods has an airborne standby policy. That means if the aircraft is put on standby by an emergency communication center, by receiving center, they are getting a report, or by a hospital saying, okay, we just got this kid. We think we are going to transfer -- or adult for that matter -- we want you on standby. If it's more than 25 nautical miles from the place they are going to, they will do airborne standby, which means they take off and start flying. If they are subsequently cancelled, that's fine. If it's less than 25 miles they'll sit --

(The speaker cannot be heard.)

DR. STUHLMILLER: -- in terms of standby. Over the last decade the Air Methods folks have worked with the emergency communication centers to have standby criteria. And if you read them they are really like, these people are critical, these are critically injured patients. So if the

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ECC gets a report or request for ambulance response they have criteria they say let's put the helicopter on standby in the situation. So you can start at the ECC level, you can start with the first medical provider on the scene, and then, of course, as the higher medical professionals on scene arrive they can say, nope, we don't need an aircraft and Air Methods will turnaround. And Air Methods is committed to saying initially whether they have the ability to respond or not.

There is now a rule that requires every flight to go through an operational control center. If you have more than 10 aircraft in your system and since Air Methods is a national company, they have more than 10 on their certificate to operate. So any call has to go through an operational control center for clearance before it can be accepted. So there is now a new process for any air ambulance company that owns more than and operates more than 10 aircraft on the same certificate. You have to go through

this preapproval from your OCC before the local aircraft can go. So it adds a couple minutes in terms of, are we allowed to go or not, from the FAA and the Federal Aviation regulations.

So it's not an instantaneous, yeah, we can go. It's a we have to check weather and check the OCC and couple minutes later Air Methods calls and will say yes, we have available. And then if it's more than 25 nautical miles away they do airborne standby. Same thing for launch, it might add another minute to check with the OCC. That's a new Federal regulation that started earlier this year.

That's how I think we talk about peds trauma. Now, I know the RTAC in Hudson Valley is one of the first to discuss this. Other RTACs are not discussing what do we do with pediatric trauma patients so this will play out. And I doubt if you'll have a statewide directive soon because this is really where it's starting. Pennsylvania has one where if you have another -- if you have

a pediatric trauma patient and -- you go to a pediatric trauma center if it's 30 additional minutes away. So you can go an additional 30 minutes prehospital transport to a pediatric trauma center. If it's more than 30 minutes additional you go to the closer trauma center, that's how Pennsylvania statewide has their regulation or whatever it is --

DR. MURPHY: Guidelines.

DR. STUHLMILLER: Yeah, whatever -- but it's expected to be followed and apparently audited by their trauma system.

DR. BERKOWITZ: Is that physiological, anatomic, or include mechanistic --

DR. STUHLMILLER: If you are defined as a pediatric trauma patient per ACS you can go additional 30 minutes prehospital transport time, you are expected to.

DR. ARSHAD: I'm particularly empathetic towards our prehospital care providers in this scenario because there is a lot of ambiguity here. I think they are capable of identifying the sickest children and the

diagnostic criteria for transfer to level one trauma center, they are there, we know that's going to improve outcomes. What we are asking them to do now is find the patients who may have a concerning mechanism, but nevertheless are hematologically stable and may have not --

(The speaker cannot be heard.)

DR. ARSHAD: I don't think -- you know, if I was deployed prehospital and responded to that patient that I have a CT scan, eyeglasses, et cetera, that can make those same diagnoses. And like we said, time may have manifested different physiology.

So what I would say, you know, just trying to always elevate the level of care is, can we create a demographic of the types of pediatric patients that are ultimately transferred to the level one trauma center, develop some scenarios and cases around them and maybe film a training video or webinar and say, you know, these are commonly -- these are the five to six types of pediatric trauma patients that are most commonly

transferred here. Let's really dig into that and see if there are opportunities for highlighting a pattern and educating our providers so that, you know, we can address some of the ambiguity, highlight that demographic that ends up getting transferred and, you know, elevate the overall level of care and reduce the confusion.

DR. MURPHY: I think that was a motion by Dr. Arshad to make a video program with CMC and medical control contact hours.

Did I hear that correctly?

DR. ARSHAD: Yeah, I think --

DR. MURPHY: Okay --

DR. BERKOWITZ: I can get the data. We have a -- so we can work on that.

I want to discuss the ambiguity because I it's something -- we are talking about two things at the same time. We are talking one thing about the really sick kids, we know what we want to do, we need to find a way to get there. And then what we are talking about is the not so sick kids. Now you have the CDC guidelines suggesting they go to

pediatric trauma center, who show up in a non pediatric trauma center and there is a question of what to do. And I think that once the kid sets foot in the trauma center to some extent I think that the CDC field triage is gone because they are not in the field anymore, they are in a hospital. And the question of --

DR. MURPHY: And we make a decision.

DR. BERKOWITZ: Exactly, the docs make a decision. And what does happen is that there is variation with -- from hospitals about when they feel like they need to transfer those kids. And, of course, it's at their discretion, but they don't have to follow the CDC field triage criteria. It's just a matter of what is in the kid's best interest. Let's just send them down because they had a fall, you know, sometimes greater than their height and they look great, doesn't help anybody.

DR. MURPHY: Mr. LaMarca?

MR. LAMARCA: I think that one of the issues -- which I wasn't going to bring up,

but maybe bears on it -- I image that most of provisional trauma centers or those obviously looking at the critical time for pediatric patients and trying to transfer them out, it may take an hour or so. However, going into some of the centers we are told by some of the staff, why are you bringing pediatric here? We don't do pediatric. That's not true. They do pediatrics. Again, that is what is creating a bit more of urgency to get it straight.

EMS is kind of a bit in a quandary perhaps some of the --

(The speaker cannot be heard.)

MR. LAMARCA: -- what I understand from the conversation last Friday was that what we are presuming -- and take this out of the pediatric realm -- even for adult trauma some of the patients bringing into level two, level three, who we believe have a capability to --

(The speaker cannot be heard.)

MR. LAMARCA: -- with medical problems cannot and then we transport them out.

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Years ago it was a simple thing, we had eight categories of hospitals, we had them on a chart, we knew where to go. Now is the issue of trauma centers, two, three, one and basically if you say take an open femur fracture --

(The speaker cannot be heard.)

MR. LAMARCA: Why did we waste time? Somehow we have to pierce the veil and find out -- I may not be putting it correctly to say this -- but either you take it, or you can't take it. Because that retransporting the patient might be on your dime, not ours, because we could have made a different decision had we known.

DR. PAPISH: One thing that sort of always repeats itself is a lot of -- a lot of the level two trauma centers have the capacity -- basically a level two should be able to take care of almost anything a level one takes care of. But there are always certain specialty issues that tend to be limited and it's really limited by the supply of physicians that can handle acetabulum

fractures or complex pelvic fractures because there is very few orthopedic surgeons that will deal with those. So that's an area that I see kind of uniformly, so an open femur -- actually anyplace can take care of open femur fracture, but if the acetabulum was fractured as well and may need operative repair, those will get transferred down to Westchester. I think that's true of all the level twos because there is no one that really does that except that in order to be a level one they need some guy that can do it and there is not a lot. So that's the most common scenario that happens --

(Everyone is speaking at once.)

DR. PAPISH: -- there maybe a fracture up there --

MR. LAMARCA: -- I had a conversation with hospital administration, I know special surgeries, sometimes you have them, sometimes you don't. If you really want to improve the system we need an up-to-date chart that we can see and say, listen, this is clearly beyond them. Why do I take it in and waste

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their time and then take it out of service to do a transfer? We will call ahead and even if the trauma --

(The speaker cannot be heard.)

MR. LAMARCA: -- really we have to be protocol driven. We have to go on physical findings and make that decision right then and there and that will save us time. I understand that it doesn't behoove any of us to have the patient in the wrong place, to waste more time and get a patient to a level one hours and hours later.

DR. MURPHY: I think what Mark just said -- Dr. Papish just said, you know, every level two trauma center should be able to take the majority of fractures except for the ones we see that are just so catastrophic and require a higher level. And, you know, that's, I don't think a question. But when you are going in is that nurse saying that to you or that's the ED doc saying that to you, why did you bring the patient here?

MR. LAMARCA: Yes.

MR. BENENATI: I second that --

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(Everyone is speaking at once.)

DR. MURPHY: Then it has to be looked at why is that an institution a level two trauma center then because I think you are talking about level twos.

MR. LAMARCA: I don't think the staff nurse or staff ER physician -- unfortunately to the EMS unit coming in, who do they see first --

DR. MURPHY: Well, remember what happened when we got rid of backboards --

DR. PAPISH: It's still happening.

DR. MURPHY: Well, I think there is always issues, but I think that -- and we probably could clarify a little better the problem is it changes so much.

You know, I was going to announce and I started to before that Orange Regional now is a level two trauma center provisional. They have a year to get an ACS visit audit and then go from there.

Like you said, that changes occur, but I think that we have to -- you know, I don't know if there is a like -- before there was

so few trauma centers that it was easy for us to make the flow diagram to be honest with you. Right now with it being a dynamic process I don't know if we can do that. But I think the best thing that a prehospital person has is pickup the phone and talk to medical control and ask the question.

MR. BENENATI: First of all, I applaud the group for having this discussion, especially the pediatric trauma. Certainly State data is pretty clear that all of our patients are not getting where they need to go. There is a huge educational component that's needs to go along with this, but I think it's important that we continue to move a TAG forward to look at, see if we can develop criteria, see if we can all feel comfortable with the EMTALA thing. I know that most of us feel we are okay there, but we need to satisfy that and bring the State trauma group into this and if we can just continue to move this forward I think we can report back as we go on. But there is some huge educational components because a lot of

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EMS providers want to pick that patient up and get them to their local hospital regardless of their capabilities and I don't know that that is an appropriate decision in all of the cases.

DR. BERKOWITZ: Just for my -- is that why did you bring the patient here? Is that happening only pediatrics, or adults as well?

MR. LAMARCA: Mostly pediatrics. Outside looking in I thought maybe somebody was -- from the State or College of Surgeons with an audit and because then it seems to be a paranoia from some of the staff, we don't do pediatrics, we want the patient out. It seems almost reactionary to something going on. Maybe people are looking.

(Everyone is speaking at once.)

MR. LAMARCA: -- it seems in a relatively short time we got that response from a couple spots.

DR. MURPHY: The safest thing though is, if you decide and bring the patient to an institution, they have an ED doc there, then that's it, they go and evaluate the patient

and decide the best thing. For right now that's the way we should do it and make sure there is no big decision making in the field. If they can't decide, then they bring the patient to the trauma center right next to them or the closest one they can get to. We can't have them sitting in the field wondering and watching, feeling like am I going to make the wrong decision? There is no wrong decision. They make a decision, they do it and we go from there. We are going to be able to find and fine tune maybe a process here, but we have to still continue on because we are you know a day-to-day basis doing this stuff.

DR. BENNEK: Ultimately too, who do you even call? So if you are out in the field today with a pediatric patient, first of all, whose pediatric definition are we going to use? What age are we gonna -- I mean we are talking about signs of puberty. I think that's something that needs clearing up as well. Because there are several -- I think three different standards for pediatrics.

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Additionally, do you call your local hospital, or your local level two, or should we be calling our pediatric level one and saying should the patient be coming here?

So that's -- so that's a question as a provider in the Hudson Valley, can I call Westchester, which is outside of our region, and get medical control where that physician says, yeah, bring that patient to me, or no, you don't need to bring that one, you can bring it to your local level two.

DR. MURPHY: I would call your medical control, the closest medical control. I think bombarding these guys with calls at the medical center, can you imagine them leaving the patient to come to the radio for that volume? Maybe it's not a lot, but still I think, you know, you need to ask your local medical control.

DR. BERKOWITZ: They are the ones that you know, I believe the RTAC said, you know, we are using the ACS definition of pediatrics, fourteen and above is adult. We should all be using that --

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DR. MURPHY: Yes.

MR. BENENATI: But see the regional protocols or the collaboratives don't use that. So that creates a challenge for us in the field because our pediatric definition is different than the ACS. And that's -- obviously that's where Dr. Dailey getting in on this conference call would be helpful as well and he has agreed to do that, because that's a challenge.

SPEAKER: It seems like when we went to specialties with stroke centers and STEMI Centers it was a no-brainer, I'm going to either send them to the hospital 20 minutes later. But it seems to be a larger issue when we have a pediatric trauma patient going, I'm going to wait the 15 minutes for helicopter to come and take the patient to the proper medical facility. I'd rather go to the facility that I know it's a hospital, but they are not the proper facility for this patient to be at. I think that's the problem we are having with EMS providers right now because it's a pediatric patient the stress

level for the provider is higher. They are like, okay, I have a really sick kid. I don't want to wait for a helicopter or drive that 45 or 50 minutes down to Westchester. I'm going to go to the hospital and it's going to be their problem to get them down to Westchester even though the outcome now maybe worse off for the child because we didn't make the right decision. I see that because we have had this conversation about using, you know, an aircraft to get patients to the proper facility from Dutchess County because of where it is. And then the problem in Dutchess itself that we do have two trauma centers a mile apart and a mass call volume around the hospital that I can get them to a level two trauma center in five minutes even though I know that patient should have went to a level one, I don't want to wait that extra 10 minutes with this patient because they may deteriorate. We talked to --

(The speaker cannot be heard.)

SPEAKER: -- everything else and trying to come up with a training scenario. But I

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think that's where we are kind of losing the pediatric patient needing to go to a specialized facility is getting lost in the process. And if it's an adult having a STEMI and I'm right across the street from -- I'll pick having a STEMI. I'm at the diner having a STEMI Mid-Hudson is right across the street, your still going to drive a mile down to Vassar because that's the hospital I should go to.

DR. STUHLMILLER: Can I make two suggestions? The first is that if you do have -- for pediatrics -- if you have a patient that meets the ACS criteria for trauma patient, that we speak that language. I think we don't say, they have physiological criteria, they have anatomic criteria, mechanical criteria, comorbid criteria, that makes them a trauma patient. We have to really document in that mind set.

We talk about stroke as assessing them for stroke and we use Cincinnati and we talk Cincinnati. When we talk trauma, we don't talk ACS field triage criteria. We talk

mechanism and everything else, what the vitals are, how we found them, what happened. That's kind of not the same language we are expecting people to use to make a decision. So give our reports if we are going to call our local trauma center, say, there is no physiological criteria, patient has one anatomic criteria, it's two long bone fractures, I suspect. And then the doctor can, oh, we can't handle two long bone fractures because I know our orthopedic surgeon is doing something else and they say don't bring that patient here, can you get the person to another hospital?

I think if we present it in that way -- in the way we are trying to have people assess patients that would be great.

And then the second, regarding air transfer, the helicopter will go whenever, wherever -- pardon me -- when they are able to fly. So if you say, I'm not sitting here waiting, I'm going to start going, then you can land at some landing zone that is available and able to be setup, or a heli pad

at a hospital. It's been said a couple times, just remember EMTALA, what is triggered when the patient, someone representing the patient, or anyone observing the patient says, I think they need to be seen right now, and that's when EMTALA is triggered. So if everyone involved says, we don't need to bring this person into this hospital that we are pulling into the grounds of, then EMTALA is not triggered. It's not triggered until someone requests a medical screening examination for that patient. So if you are in a system where you can rendezvous with another transport agency, whether that's an ALS ambulance, whether that's the air ambulance, whether that's a boat, whatever, you can meet a person on the grounds of the hospital and put the person in the other transport vehicle and have them go to the hospital without triggering EMTALA, unless someone requests a medical screening examination from that institution that you are on the grounds of.

So that's been interpreted more than

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once by the federal --

(The speaker cannot be heard.)

DR. BERKOWITZ: I hate to disagree a little bit on the EMTALA. My understanding is it's triggered when the patient enters the campus, the hospital area. Someone who passes out within view of the ER, no one is asking for medical screening exam, you are still responsible from EMTALA perspective to respond. But EMTALA specifically had exclusions for the use of hospital heli pad for either as part of the EMS standard protocol for using that pad, or with an agreement with another facility for doing interfacilities. Meaning, if you want to fly someone from -- a patient at Vassar from Mid-Hudson to wherever, if Vassar didn't have a way to do it, that would be fine too if you have a written agreement. You wouldn't have triggered EMTALA by driving close to Mid-Hudson, but that's my understanding of EMTALA. Either way --

DR. PAPISH: The point is it's okay.

DR. BERKOWITZ: Exactly. You

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definitely -- there is nothing wrong with saying this kid is pretty sick, we are starting to head towards the hospital, but we will get the helicopter there too. And not even -- and maybe not even, you know, tell the hospital that we are going into the hospital and say make sure your security knows that we are going to be using your heli pad.

MR. LAMARCA: I think one of the questions with an exchange of e-mails about EMTALA -- going back to the statement a couple minutes ago -- if there is confusion, call into medical control. And if they call into medical control are we binding our --

(The speaker cannot be heard.)

MR. LAMARCA: -- to the hospital. I know there has been issues about medical control and EMTALA, but I'm calling in and giving you a history of this patient. You say, well, I think that sounds reasonable, take them to the heli pad and take them out, would you have considered that --

DR. MURPHY: You are not bound, again,

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because it's like say, you are driving from Sullivan to New York City, you are transporting a patient and the patient goes bad and you call medical control at St. Luke's or Orange Regional, you are getting information from them, they are not bound by EMTALA because they are driving by and asking for medical control. That's under a regional setup for our protocols for our medical controls both on-line and off-line to assist you guys.

MR. LAMARCA: You are going to pass though the heli pad --

DR. PAPISH: At the end of the day we should just be concentrating on what the right thing is and not the legalities. What is EMTALA? Ultimately, it's the hospital gets a $50,000.00 fine, whether it goes to federal court or regular court if there is a malpractice trial. Other than that, I mean, it doesn't really affect us and we should probably just worry about best medical care. Because if we are working on doing the best medical care, the EMTALA issues aside, or

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where the venue is can be settled later if something bad happens, but we are doing the right thing and that should be --

DR. MURPHY: Okay, healthy discussion. Good job, Dr. Berkowitz.

DR. BERKOWITZ: That's not even what I was talking about initially --

DR. MURPHY: Somebody hit him and wake him up.

Dr. Stuhlmiller, I'm going to back up for a second.

Did you want anything under helicopter report?

DR. STUHLMILLER: No, thank you. Sorry, I was a few minutes delayed this morning.

The only request from the helicopter committee would be that when the collaborative protocols are shared that we also share the helicopter operations guidelines. As there used to be an air medical utilization protocol in the collaborative protocols and there is no longer one. And so if -- and we have done a lot of work over the years, even before I

arrived in the region, a decade or more ago, that these guidelines have been in practice and shared and in operation. So I just request that we do that and, of course, the committee will continue to revise those guidelines as new occurrences happen. And we will have to now that American College of Surgeons verification trauma centers occurs so we will unlikely continue to follow the '05 -- '05 New York State Department of Health Directive from 2005 and instead follow for trauma at least, the ACS criteria for trauma patients.

DR. MURPHY: Okay. Thank you.

Next, quality improvement. Jeff?

MR. CRUTCHER: I'm just about finished with this year's study for cardiac arrest so we will be looking for a new topic for next year. And that's it.

DR. MURPHY: Maybe we should do trauma.

MR. LAMARCA: Pediatric trauma.

MR. BENENATI: I would like to say that I think we should be looking at appropriate destination regardless of the special type.

We are getting more of the specialty type of transports. I think that that is something that we absolutely need to look at to raise the awareness and see if we can improve the system. There are patients of all types, stroke -- varying levels of stroke, STEMI, and trauma, that I think we need to begin to examine.

DR. MURPHY: Okay, nice segue.

Protocol committee, Mr. Benenati?

MR. BENENATI: An update went out with regards to credential examination over the last few months -- or several months. We have changed the process. It now requires for prehospital providers that they take an open book exam here at the regional office. Currently they have to get 90 percent on each module to be considered passing. They are given two hours to complete the exam and if they don't answer a question because of time, it's marked as wrong. And they are given paper copies of the protocols rather than electronic devices so they cannot use an electronic device to take the exam. We have

adjusted the passing rate and we are continuing to evaluate, continue to make sure the system is going to be effective. We don't really know where this will end up. We need to change the system somehow and that's where we started.

At the SEMAC last week the collaborative -- the new collaboratives were approved. There is not currently a timeline for the roll out. Certainly from my perspective I don't see that we will be implementing them much before the beginning of the year, maybe before that, but there is a lot of work yet to be done.

We are looking at the collaborative training program as well so that everybody in the collaboratives is receiving the same exact message in the same fashion.

Additionally, several policies were pulled out to make it more of a medical collaborative protocol. Those policies will all need to be written at a regional level. Again, the collaborative group is hoping to come out with a template that you can simply

put your name here. But that work is yet to be seen and so there is still a lot of work to be done in that -- toward that effort.

We are already discussed pediatric trauma and the TAG will continue to move forward. We will get a conference call scheduled once Bill returns.

The next big topic that -- actually I see on new business anyway -- that I will open and maybe Dr. Murphy will segue right into it -- is the New York State has adopted BLS acquisition and transmission of 12 lead ECGs. It's been discussed twice at the protocol committee so far. As you can probably imagine, we have both ends of the scale represented here. There is some concern that we add yet another specialty piece for BLS providers. While the system is being stretched, questions about competency, agency health, all comes up, accountability, medical control involvement, remember these are BLS agencies, BLS support at the regional level, and the fragmentation and the closing and the reduction in volunteer response that

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we are beginning to see. So does this lead us to some additional strategic planning that needs to be on at the region? Can we just approve the 12 lead? Some say if the region were to adopt this agencies would go out and buy the devices. The challenge is that the hospitals that they transport to need a receiving device. The deal with BLS acquisition is that you cannot interpret it in the field so the device needs to be a device that transmits the findings directly to the emergency department and they make the decision whether or not the patient needs to go to a STEMI center or can go to an additional facility. So it's not a simple discussion, but rather complex.

And that's all I have. So Dr. Murphy, if you want to continue that conversation a little --

DR. MURPHY: Yeah. I think what -- this kind of segue's into both new business and SEMAC because we passed this at SEMAC.

The point there was, if an agency, a BLS agency wants to acquire the technology and

equipment -- we are not going to make anybody do it because it's an expense -- why not have more information? So that's what it was, acquisition of the ECG, not interpreting or doing anything else with it. However, if we identified and saw people -- you know, an elderly woman who is nauseous and diaphoretic, they acquire an ECG and she's having acute MI, they are going to go to the STEMI center versus just going to the hospital right next door to them. So the acquisition, what we are looking at is could it get us closer and quicker to acute MI patients and help?

So that was the point behind it, not so much that we -- you know, make it mandatory, we would not. All these things start with a certain process. Now, to be able to do it the BLS agency, just like if they are doing Albuterol, just like if they're doing Epipen, has to apply, has to have a medical director on board, and has to have somebody sign off on it. So there is a process, they have to be more of an established, organized BLS

agency than anyone else. They have to have that process already in place. So to me, I wouldn't want to hold up having another venue, another avenue to have more information delivered, especially in some of our remote areas where, you know, we rely on these people to take care of the patients and be the first on scene.

So that was the point behind it. SEMAC had passed it and it comes down to our REMAC for us to vote on it and we have to vote on it today.

Do you want to pass it around?

That's the official Department of Health BLS acquisition of 12 lead EKG protocol. And people can look at it. Because we have it on the business today to vote on.

But that was the point behind it, I think, not so much that, you know, it's a thing where -- that we have to be worried about per se, but it's a process. Just like we advance their care in other avenues, you know. When I first started they didn't do, you know, glucometry even -- Andy?

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MR. LAMARCA: Just to put it in perspective, where this works well is Nassau and Suffolk County. A central receiving spot where they transmit and that determines if it's STEMI and directs them to whatever hospital to appropriate. Here, in our region, we don't have that.

Secondly, we currently are transmitting 12 leads to STEMI centers that are not receiving them, or are not getting on-line and talking to the field. So you superimpose BLS in blind, can't make any of this determination. Again, if they have chest pain, somebody they suspect, they should be making that decision to go to STEMI based on the complaint. The other side is -- and we discussed this at the meetings -- we have bastardized the standard of care for BLS in this region. We have some that choose which additional skills to do, like glucometry, some do it and some don't want to. Some will do albuterol, the click and inject, some do, some don't. We do not have uniform BLS standard of care in the region.

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I think before we add something else maybe we should refocus and say that every BLS provider in this region should be able to use internasal Narcan, they have to wait for the local police or fire department to show up to do that. That's just disgusting in my mind. I think we should look at it before you add something new and something sending it in blindly, if they have the receiving center that we need a physician to check it, to evaluate, and direct them where to go. Before we do that there is so many other things they could be or should be doing to get uniform standard of care. That's my take.

DR. PAPISH: I feel like it's two different issues really. One is the big issue of bringing the bar up to standardized care across the region, but the issue of 12 leads really is -- I mean, we are not weighing down the agencies that are not doing these other things with the 12 lead because they are not going to be doing it -- at least right now. Whether they have volunteer

issues that are preventing them or just the cost of buying machines, whatever the issue is. But what this does do though is gives us an opportunity for the agencies that are practicing to the limits of their license -- certification, to do something better for the community. So I don't see how --

MR. LAMARCA: That's not really true. They could be doing none of the rest and just do this. What I'm saying is it would be nice if there was a carrot and stick, if you are going to do this, do the rest first. Improve the standard of care --

DR. MURPHY: Again, we haven't pushed anything on anyone because of finances. And we didn't want to say that, you know, these volunteer agencies that don't have a budget has to go out and buy X number of glucometers or do X number of things --

MR. LAMARCA: They get free internasal Narcan and don't do it --

DR. MURPHY: Yeah. Yeah. But they need to be married to a medical director and work with medical director. I think that's

probably where most of the problem comes from with the BLS agencies, never really had that, they had somebody that sometimes was a medical director and most of the time not and just did their volunteer agency stuff.

But I think Dr. Papish is bringing up a good point. We have to continue to move forward I think. I think we always have to continue to strive to increase care, increase the level of care. And even if they have a problem transmitting it, they are still walking in the door with a 12 lead. So you have --

MR. LAMARCA: They are not --

MR. BENENATI: -- they can't even print it, it's a blind device so only the receiving --

(Everyone is speaking at once.)

MR. BENENATI: -- so the person -- the agency that does this first will need to buy their equipment and they need to buy the equipment for the hospital as well.

DR. MURPHY: Well, not if they are hooked into the same because most of us use a

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certain type of --

MR. BENENATI: It's a different system. They won't be able to -- they can't go to the Zoll system and they can't go in the Physio system. It's a separate device -- it's a separate device that they need to purchase that doesn't even give them a screen in the field.

DR. BERKOWITZ: Just from my perspective, because we received both Zoll and Physio and just being able to -- I mean, I don't know, we try very hard to make sure that we get all the transmissions, but just getting two different feeds is a nightmare. I mean, a third feed that is not compliant with each other and no one wants to play, you talk to Physio, you talk to Zoll, it's their fault, their fault, you know, whatever. We have a better system, why can't they send to us, pay us for -- whatever it is. That is a really operational barrier especially in the absence of a dedicated receiving center, that we still every few months have something that happens where we stop getting transmissions

from someone, somehow, and you have to have a monitor setup, whether it's the computer setup, wherever it is and figure is out it's another layer of complexity. It is going to be challenging. I'm sure that -- on the other hand I do know of an agency in our region that they provide this and it's because they have chest pain patient that is -- get transported BLS and they can't -- and they don't know and they feel bad when they find that out. And I feel for them and I think that in a limited way there are a probably a few agencies this could be useful, but from the hospital's perspective it's going to be challenging.

DR. PAPISH: Who makes this?

MR. LAMARCA: It's a couple different ones, it's not --

DR. PAPISH: It's all Physio?

MR. LAMARCA: No. No --

MR. BENENATI: The one that Dr. Dailey had at the meeting I think actually is an internet based, cellular to internet and the initial doctor that interprets it I think was

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in Israel that then phones the hospital and then faxes the transmission over as well.

MR. LAMARCA: I forgot that part --

(Everyone is speaking at once.)

DR. BERKOWITZ: A doctor reads it in Israel?

DR. PAPISH: Except Friday night to Saturday night --

(Everyone is speaking at once.)

MR. HUTCHISON: I'm Jim Hutchinson from Sharon Hospital. We have in Connecticut adopted BLS EKG, it's been at least a year. The study closest to us was in Danbury with the local squads around there and currently Sharon Hospital, 50 percent of our Connecticut squads are participating in the program. And we are where they would send the EKG to, so they send it directly so that medical control can see it and the decision is made on our end and not sending to a tertiary hospital, if that helps.

And as for the machines themselves, Physio is making that machine that you are describing, but they are no longer

manufacturing it, or they don't have access to the blind one. So it put us in a bit of a bind where what we are doing is a lot of the squads are taking old equipment from commercial squads that are advancing so they will still have a monitor. My squad has just purchased three units and it doesn't just do EKG, it also checks chest compression rates and so -- and so it's much more functionality than you think.

DR. PAPISH: Is there a rule that says it has to be blind?

DR. MURPHY: Protocol is there --

(Everyone is speaking at once.)

DR. STUHLMILLER: Operationalizing this -- the policy says the receiving hospital. I'm certain that's purposely vague. What is the intent? That it goes to the hospital where your medical director works, if your medical director works at a hospital? Does it go to your local hospital? Your community? Does it go to STEMI center that you might be transporting the patient to if there is a STEMI? What would be the

receiving hospital if we were to approve?

DR. MURPHY: Well, what it's set up to be is who you are going to talk to and direct it towards. The equipment that Dr. Dailey had brought to the meeting was that you hook it up with a specific institution. And so you work with that institution just like they are talking about in Connecticut so you would be transmitting it to them.

DR. STUHLMILLER: What is the intent, which institution --

(Everyone is speaking at once.)

DR. BERKOWITZ: Medical control --

DR. STUHLMILLER: So on-line medical control hospital?

DR. MURPHY: Yeah. The one you designate -- the receiving center you generally go to. So, you know, Goshen would be, you know, Orange Regional. Goshen Volunteer Ambulance Corps, as just an example, would be Orange Regional because that's where they bring the majority of their patients. So they would work -- setup a system to be able to transmit the EKGs.

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There is many issues. I don't think it's full proof. However, I just find that I think if we can move people along, have people do things that will help us, I know there is issues of people not doing glucometry and not doing albuterol and such, but we can't force BLS agencies to do certain things. But we can give them the auspices and the ability to upgrade their care and give another higher level of care and another bit of information that helps the doc in the ED and that was the premise behind the New York State Department of Health.

DR. STUHLMILLER: And I agree it's important to have everyone practice at the top of their license or certification and this would be a wonderful step toward that for BLS providers. And I feel for your sentiment that BLS providers out to be practicing at the highest level and doing all of the things medically available to them to help our patients.

I don't know if I would hold off on this in the hopes they would do Albuterol and

internasal Narcan and glucometry, but I would question should we recommend that these go to the STEMI centers? So the STEMI centers can say to the BLS agencies, yes, that's a STEMI, bring them here, please, or no, you can go locally. Much like we were just sort of alluding to with trauma, should we call and have them go the STEMI center so there would be fewer hospitals that have to purchase receiving centers. Those hospitals more likely are already used to getting more phone calls and the physicians would be more willing to take the phone calls and spend the time to look at the transmitted EKG rather than relying on every hospital in the Hudson Valley to buy something and have all of those physicians willing to be available to read an EKG at a moments notice.

DR. MURPHY: Yeah, I mean, I think part of this whole issue that we look at this from the State and adopt it if we want, we make it the way we want because we are the officials in this area. The Hudson Valley -- we know the Hudson Valley, we know what the

capabilities are, we know what we have so we can designate it as the receiving institution is a STEMI center.

DR. BERKOWITZ: Do we have an idea of what people's interests are, how many agencies?

DR. PAPISH: We are talking about probably two agencies --

MR. BENENATI: I think I heard two, so far we've got two --

MR. CRUTCHER: Yeah --

DR. MURPHY: It's not a voluminous --

DR. BERKOWITZ: So this maybe a very specialized limited program that is to, you know, deal with gaps that have been identified in certain regions, which in that sense, it's great. But if every BLS agency is like, I'm doing this, I can see how that would be an issue. Where it's just a couple agencies saying I'm going to do this they will find a way to make it work with the hospitals.

DR. MURPHY: And I think the BLS agencies that become more involved and take

the care to another level and do these other things have involved medical director and I think that's the problem, Andy, with the history. Is that we haven't always had the communication between BLS and ALS and to this body itself. And so I think sometimes we can have a process where you have a more involved medical director with a BLS agency.

MR. LAMARCA: Some involved medical director are still --

(The speaker cannot be heard.)

DR. MURPHY: Correct, I agree with you. You know we've had this discussion before, I mean --

MR. PARRISH: And that's the problem in Ulster County, I have a couple squads that want to go to BLS and Narcan -- glucometry and Narcan, and their medical director says, no, they won't sign off on it.

So what I think we need to do and my recommendation is we put together, like Andy said --

DR. MURPHY: Yeah, get a new medical director, all of us said the same thing.

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MR. PARRISH: It's not that easy to get that. I wind up getting one of my ER physicians to sign off to the medical director because they can't find somebody in their community.

DR. MURPHY: That's the best person for it anyways, right? I mean, you know, we have had in the past we talk about an agency and I'm like, who is the medical director? I've never even heard of the person. So it's much better for it be an affiliated ED doc or somebody in the -- what we are doing, you know, in the gist of it that is staying up to snuff with what we are doing.

MR. PARRISH: Can we develop a list of who all the medical directors are and send something to them and say -- like Andy said -- hey, this is the level of care that we have gone to and we strongly recommend that you work with your agency to get to this level.

DR. MURPHY: Absolutely. I think you have a few directors in your area right here that can -- can address that issue.

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There is no question it would be helpful to have more involvement, it would be helpful to have more communication, just like when we did the educational roll out before. I mean, I think people were receptive to new information and that were even out there wanting to get them involved, wanting them to come to higher level, wanting them to bring it up a notch. So I mean, the more we can do the better off we are, volunteerism is a dying breed, there is no question. But I don't think that means we stop what we are doing. I don't think that means that we put a ceiling on what people can do. I think we have to allow people to do and to move forward and that was my point, it's just acquisition. And if they can do it and they have a system setup and somebody to do it with them and a medical director then I wouldn't hold them back.

DR. ARSHAD: I think the way this particular policy is written, the EMS agency in coordination with the hospital can elect to do this voluntarily. So it's not forcing

anybody, it's not peer-pressuring anybody. If you have a system and you feel in combination with the receiving medical center that your patient population will benefit, you can pursue it.

DR. MURPHY: Yeah, and not to make it a you know a monetary --

DR. ARSHAD: Mandated.

DR. MURPHY: Yeah, that's why it's not mandated.

DR. PAPISH: So make a motion and we will vote.

DR. MURPHY: Yeah. You want to make the motion?

DR. PAPISH: Yeah, for the motion that we begin permitting 12 lead acquisition programs among the BLS providers in the region.

MR. BENENATI: After you get a second --

DR. MURPHY: Okay, I'll second that motion.

All those in favor? Unanimous. Thank you.

What?

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MR. BENENATI: Just technicalities, the State does talks about BLS and advanced emergency medical technician levels. You know, certainly that's another big topic at the State level so maybe for the motion you should revise it to be consistent with the State protocol -- but that's up to you.

DR. MURPHY: Yeah. I think we have to --

DR. PAPISH: It has to be consistent --

DR. MURPHY: Yeah.

MR. BENENATI: So then it's basic life support and advanced emergency medical technician level.

DR. PAPISH: Talking about the twos and threes, that don't really --

DR. MURPHY: Yeah, yeah --

MR. BENENATI: That's correct. And, again, the State right now is examining -- reexamining that whole issue.

DR. MURPHY: Yeah. That was a huge topic at SEMAC also.

Okay, so we will revise the verbiage of the motion and just add it for basic life

support and advance EMT providers.

MR. BENENATI: And maybe the other question is should it go to the protocol committee or another group to develop a process? Because obviously there is process we're going to need to be developed at a regional level before the approval is granted, right? Or not? Do you need a process?

MR. CRUTCHER: It shouldn't really be any different than any of the other adjuncts that are out there.

DR. MURPHY: Yeah, because we don't oversee the glucometry and Albuterol, but they have --

MR. BENENATI: This one does require approval letter --

DR. MURPHY: Right. Well, all of them do too because they come through the office and we kind of rubber stamp it, so I see every single one that comes through. But they have to have the appropriate paperwork filled out, they have to have the protocol, they have to have the medical director, they

have to have -- you know.

MR. BENENATI: As long as Jeff is good with that, that's all that matters.

DR. PAPISH: Jeff will do it.

DR. MURPHY: Thank you.

MR. BENENATI: I'm on board with that.

DR. MURPHY: So the last thing under new business is the collaborative protocols that Mike had brought up.

REMO presented their protocols to SEMAC and had them approved. It was the same protocols I gave you at the March meeting, however, what they were had some changes in verbiage, changes in semantics and things, we saw some literacy and kind of technical issues the way we have written some things. So we have adjusted some of those issues and corrected the typographical errors and made it into the same format. Like Mike had said before, we moved out a lot of policies that belong under each REMAC and just kept it as a medical collaborative protocol. It did pass the -- remember I told you about the patellar dislocation? That did pass. I can't believe

SEMAC allowed it, but they did. So that protocol is in there. And the version you all saw was basically the version that went through. So we put it out for a commentary, most of the material came back, we forwarded it on to the collaborative committee. Hudson Valley had quite a few comments and most of it was pretty straightforward. I didn't think anything was unusual. However, there was one part -- Mike, do you want to bring up the part about the disclaimer?

MR. BENENATI: How about at the next meeting?

DR. MURPHY: Okay.

MR. BENENATI: Because I'm assuming we are adequately prepared to have the discussion and maybe we will learn a little more about the protocol by then.

The discussion is going to evolve around the use of judgment by field providers more than written protocols that we have had. So providers, provided the paramedic has the skill, provided the medication is in the box and they contact the medical control, the

provider medical control has additional responsibility. So but that's going to be a huge educational component when we roll the protocol out. Because paramedics traditionally have been, if it's written I can deal with it, if it's not written I can't. So it's a change in the philosophy that we are going to have to really look at in greater depth as we move forward. It's good for the higher trained paramedic, for the lower trained it raises some concerns.

DR. MURPHY: Well, that paragraph you pulled out though is really a typical legal paragraph that everybody uses whenever they write guidelines that this does not supersede good clinical judgment and medical care. I mean, that's what everybody puts in every single -- if you look at every protocol and things it's there so that's why that paragraph is there.

MR. BENENATI: So we can talk more about it next time because we really need the physicians to have a little bit more latitude when it comes time to do something because

there is not necessarily going to be a written protocol for it any longer, but a general accepted practice and guideline.

DR. ARSHAD: So if I may piggy back on that? Again, the new one is in the clinical decision making and boils down to education. So combined with the rollout of the collaborative protocols there is going to be a robust training program with video and simulation. So tentative dates for that are July 11th and 12th, Monday and Tuesday, in Wappingers Falls. So educators from all over the State will come down and we will have scenarios designed to sort of bring the collaborative protocols to life. And we'd love for everyone to participate, certainly this is not limited to physicians, but educators of all types and varieties. July 11th and 12th, everyone is invited.

DR. MURPHY: And I think with the process there is what we are talking about is standardization of how we roll these out, how we educate people, how we bring everybody up to snuff, you know, region wide and just that

we make sure when we roll it out Upstate, when we roll it out, you know, in REMO area, when we roll it out here, when we roll it out in Westchester, that we are all going to be given the same information and people can utilize these video projects and use them as a teaching tool so that we are all there.

Now, it's good that as many people show up for this educational process as they can because this way we will all be on the same page. However, just like when the -- you know, project from Cushman and, you know, the backboard, that was a great tool that we could all use. So this is the process behind it and, again, you know, just to keep going on with providing the education in a standardized format.

MR. BENENATI: So and we really need -- Dr. Arshad is doing a lot of this and he's working with Dr. Fululer (phonetic) out of Syracuse as well and trying to develop a real progressive training program, which will take a lot of pressure off the individual agency because you will simply participate in this

program -- and I believe that's what you will be organizing on the 11th and 12th?

DR. ARSHAD: Yeah. We are recording the training scenario simulation cases, we'll produce them and load them to a learning management system that should be accessible to any prehospital provider in the State and then they'll track the participation as well.

MR. BENENATI: So that's a great effort.

DR. MURPHY: Yeah, I mean, it's just because we saw the last time it was too many open holes so this way it will standardize it all.

Now, I have on the agenda to vote on the new protocols. Does everyone feel comfortable in the room that they've been able to review the protocols in a fashion that they are capable of voting on here, or do you need me to table it to the next meeting, which is September 12th? So you have a little bit of additional time to review because it's not going to cut into our --

DR. HILL: Is there a document -- could

there be a document somewhere which sort of bullet points the major changes?

DR. MURPHY: Yes.

DR. HILL: Does that exist or --

DR. MURPHY: Yes. I can get that to you, what I sent to everybody was just the full gamut of the protocols. But I can absolutely take out of it the big things because I keep notes on every single time we meet and what some of the discussions and things are so I can get that to you, absolutely.

DR. HILL: Great.

DR. STUHLMILLER: Is there a revised version that you have --

DR. MURPHY: It's really not much changed from what you saw -- what you have from the last meeting. It's really just more typographical and the way we set it up, so I'll send it out.

So why don't we do this, why don't we table the vote until September and that way everybody can have a chance to look at it and we'll go from there. Because it's not going

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to change -- like Mike was saying we are not going to be able to roll it out until the first of year away by the time the education and everything is done. We will present it -- SEMAC is September 24th, 25th -- I can't remember, the next one. I think it's at the end of the month so we should be okay with that. I'll just check that time frame and go from there.

MR. PARRISH: 13th, 14th.

DR. MURPHY: Oh, oh yes so right after us so we can. So I will -- I will -- we will table the vote until next time so everybody gets a chance to look at it, the final version. And I'll get it out to you and put the little bullet point issues so you know exactly what the changes were from the last time. Mainly it was really formatting, additions and actually removal of things.

So that brings me to the SEMAC report, we talked about most of it.

The other thing from the Department of Health, what we did was, under our EMS the Bureau, we voted on removing some policies

and advisories -- they are actually advisories, sorry. We rescinded two advisories that were out there biphasic automated external defibrillation and the emergency care of patients with hemophilia, we rescinded those policies. They were from 2002 and 2000 -- 1997 and -- and we rescinded those as of the last meeting. Also, MAST Trousers and hyperventilation in severe traumatic brain injuries, these were all advisories that were sent out over the years 2004, 2003, 2002 that we rescinded. I can send the list around, but just to announce they are out of the Department of Health at this point.

MR. PARRISH: Dr. Murphy?

DR. MURPHY: Yes?

MR. PARRISH: With the removal of the MAST, they added pelvic binder.

DR. MURPHY: Yes. And there was one other thing, the pelvic binder we changed the verbiage on and -- there was one other thing I'm forgetting now.

MR. PARRISH: The only thing I have,

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they added the patellar reduction, which you already discussed.

DR. MURPHY: Yeah.

MR. PARRISH: And they rescinded the P-A-E-D --

DR. MURPHY: Yup.

MR. PARRISH: -- rescinded the MAST hyperventilation --

DR. MURPHY: Yup.

MR. PARRISH: -- and the biphasic got rescinded.

DR. MURPHY: I think that's it. I was thinking there was one other thing, but I think that's it.

Okay, under new programs for BLS agencies. Do you have anything to put forward?

MR. CRUTCHER: Not today, nope.

DR. MURPHY: I have a couple of announcement from the State regarding that.

The Board of Fire Commissioners has removed Woodbourne Fire Department authority to operate a New York State Certified EMS agency as of February of this year. Until

that time the department has to receive a full completed application before they take them off suspension.

So this is a notification from the State regarding Woodbourne, since it's in our area.

I mentioned that New York -- the Department of Health also gave provisional level two designations to Orange Regional Medical Center, as a level two trauma center.

There is also a great deal of information come out from the State regarding, you know, medical drug shortages, it's this never-ending constant list. And one of the things the Bureau brought out was a notification that Moore Medical will no long supply controlled substances for their customers so that was a change and transition people have to work with and move to other organizations and companies to help them out.

We talked about BVAC.

Rockland Community College has come out with a statement, through a thorough investigation into the EMS program offered at the College after review of the past five

years the College administration has determined that continued low enrollment and rising costs prohibit the continuation of the program. So as of August 31st of this year Rockland Community College will no longer offer courses in emergency medical services, paramedic and EMS training.

There was some information that came out regarding, you know, new laced heroin. We circulated this all around with pretty much e-mails and people had noticed it and it was a letter from to get out to all the REMACs, but we sent that out electronically at the time, this was back in March.

The Department of Health has also sent out -- Daniel Clayton sent out a notification for forms that you can see on the regional website, mainly looking at and directing towards blood transfusion program. Those forms are on the website and available as of this date. We have one of the only agencies doing the blood transfusion and kudos to them for following through on that process because it's been an arduous task, I know.

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That was it on my new stuff. I have to read some Department of Health citations and then we can go into open forum.

So from the Department of Health, Michael Heilbron-Rada out of East Elmhurst has received a citation, suspended for one year as of March and assessed a civil penalty of $2,000.00. The suspension is for the individual certificate and the enforcement is a matter of public record.

In addition, Rawl Steed out of New York, New York for a violation of Part 800, has -- suspended for one year and assessed a civil penalty of $2,000.00.

Also for a violation of Part 800, Joseph Smegelsky out of Oswego, New York is suspended for one year. The suspension was effective March 14th and assessed a civil penalty of $2,000.00.

Jarred Wells out of Ogdensburg, New York was given a citation for violations of Part 800 and it was effective March 14, 2016.

And lastly, Christopher Jenkins out of Hammondsport, New York, for also a violation

of Part 800, assessed a suspension for three months effective in March and placed on probation for three years and a civil penalty of $2,000.00.

I had to read all of those into the minutes.

Open forum? Anything anybody wants to bring up?

SPEAKER: I'm dealing with an issue and I'm guessing it's not just Dutchess County. A first responder in BLS Narcan use and then RMAing of patients, there is one particular police department that has told me that if they are the ones that provide the Narcan use to their patient under the Mental Health Law all patients that receive Narcan by a police officer must be transported to a hospital. If they arrive to the scene after the EMS provider and the EMS provider provides the Narcan, the rules change. They won't put them under mental health and make them go to the hospital.

A couple issues, I have been talking to the medical examiner over there about

patients using heroin and get woken up by Narcan use, we don't know if they are being -- medical control is being contacted by the ALS provider for the RMA if it's happening. Because they are coming into a patient who is now conscious, alert and oriented, without a complaint going, I'm fine, I don't want to go to the hospital.

Her concern -- mine as well -- these hard core users, as soon as everybody leaves -- and it's not a question of if, it's a question of when, once everybody leaves they're going to want their high back and once they start injecting again the next time we find them they are probably be dead. The concern seems to be, I have a couple of fire departments, I have had the police department that came up to me and myself about, can we try and get a better guideline about RMAing these patients that have basically been in respiratory arrest that have been reversed with Narcan use.

DR. MURPHY: The RMA is supposed to be contacting medical control, that's not a

question. So that has to be dealt with at the level of the agency because they are supposed to be contacting, there is no question about it, that discussion you can have with the medical control physician. I think that, you know, once the person comes in 90 percent of them in my experience are always so pissed off they want to get out of there anyway, but I make sure they are capable, they understand and they know what they are doing. I can't force them to do anything. I can't force them to have any care. And I'm going make sure I'm comfortable with it and they are awake and don't need to stay. If somebody is like kind of dofting off again, I don't let them go home, they are not capable of signing AMA.

SPEAKER: Is there anyway we can start tracking the RMA of I guess first responder, then EMS providers coming in, RMAing, making sure medical control is contacted? My concern is we have people showing up, they just come in and RMA, they get a signature and leave. I know it's happening that

medical control has not been contacted -- they have not been contacted on all uses of nasal Narcan by first responders with EMS agency coming in after the fact.

MR. BENENATI: So where would the reference be -- so if this scenario plays out, it could be police department arrives, gives the Narcan and a BLS agency arrives 20 minutes, patient conscious, alert and oriented and signs off. I don't where there is a policy --

DR. MURPHY: BLS we are not going to, only ALS.

MR. BENENATI: That's what I am saying. I don't know where BLS is going to have to do that.

DR. MURPHY: Yeah, there is not anything from the --

MR. BENENATI: I think that's what John is asking. John is asking I think for a more affirmative, any time Narcan is given prehospital prior to their arrival, it would require medical control. I think -- right? Is that what you are saying?

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SPEAKER: The New York BLS protocols state even if a patient is conscious, alert and oriented and you suspect either alcohol or drugs on board they are supposed to contact medical control and a police agency, that's part of the BLS protocol as it came in the March. I'm not sure if the BLS agencies that get there before ALS and a conscious alert oriented patient is going to RMA, I'm canceling ALS, or if those ALS providers are going to walk in and the patient is conscious and oriented, yeah, I don't want to go to the hospital. Here, sign here, and out the door they go. And medical control is not necessarily being contact. I wonder if there is a way we can say with all the agencies in the region that Narcan use by a first responder and then EMS agency comes in to make sure medical control is being contacted and these people do realize that 30 to 81 minutes -- I actually looked and that's the half life you have Narcan once that wears off -- if they go back to inject again and get the high back and it takes 60 or

70 minutes for this person to have the Narcan wearing off, we start finding -- as the ME said, I prefer them not to increase my business. I'm trying to prevent that from happening to any EMS provider where we have a patient that says, I'm not going, and they sign them off away, they go, and they didn't talk to anybody about the outcome that could happen.

I mean, I know the purpose of Narcan is to try and give that person one more chance for rehab to get them fixed, but if we leave them in the house --

(The speaker cannot be heard.)

DR. MURPHY: I think that we could make a definite strong recommendation that they follow the BLS protocol because that's the way the State put it out. And if they are going to have that capability of Narcan to their disposal they have to follow the protocol.

I don't know if that has to go out as an advisory or a reminder, I can research that a little bit for the correct way to do it, but

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it has to be from this body we can put out a letter to them. It still comes under the person that signed off on the Narcan, that's the person that is really responsible so it goes back to the medical director again. And we can put that so people understand what it is, but it sounds like it's better -- I mean, and that's okay to do, but it sounds like it would be best to look at this specific agency or is it a global county area, or is it one little hamlet? So that if we could look at it and identify who the medical director is, go right to the source and say, listen, do you know this is what is going on? You know, also that's another way to identify but you and I can talk about that, all right? Because it's very important and it shouldn't be happening.

DR. ARSHAD: I want to emphasis and I think we all agree, it's a high index RMA it should be called into on-line medical control. I've taken several of these calls in LaGrange and Arlington --

DR. MURPHY: Yeah --

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SPEAKER: -- LaGrange would be Arlington and Fairview, the Town of Poughkeepsie Police Department that does give it, their policy is if they give the Narcan that patient is going to transport. Now, if they show up after Arlington shows up and Arlington gives them the Narcan they can RMA. So we have a police department straddling the line saying, we will force them in scenario A, but not scenario B and opening up both the police department and the --

DR. ARSHAD: And that's the town or city?

SPEAKER: The town.

DR. ARSHAD: Just interesting, when you talk about these concepts from a data perspective, so Dr. Craig Manifold, EMS Medical Director of San Antonio, Texas, did a death registry study of patients who received intranasal Narcan revival how many ended up in the morgue in 72 hours. And we would all guess that there is some number, right? And it was zero. Not saying it's not possible, it just usually does not happen. And I think

the criticality of your decision making is to make sure that patient has decisional capacity and the safest way to do that is to get a full assessment, vital signs, and get the doc on the phone and run it through line control.

DR. MURPHY: Yeah, and that's not a problem. But Arlington is not going to be providing services anymore, right?

SPEAKER: No. They will -- still will be doing ALS first response.

DR. MURPHY: I thought that was changing, I misunderstood.

SPEAKER: They wouldn't be doing transports as of January 1st, but their plan is to do ALS engines, paramedic on engine and respond to EMS calls.

DR. MURPHY: Interesting, okay. So there are going to throw them up onto the ladder, then we are ready to go?

DR. ARSHAD: They will reach heights they have never reached before.

DR. MURPHY: Okay, open forum, any other issues?

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Anything anybody wants to bring up?

Can I have a motion to adjourn?

DR. ARSHAD: Motion.

DR. GREENHUT: Second.

DR. MURPHY: Thank you everybody for coming.

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

Yvette Arnold