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HUDSON VALLEY REGIONAL EMERGENCY

MEDICAL ADVISORY COMMITTEE

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MINUTES OF MEETING, held at the offices of Hudson Valley Regional EMS, 33 Airport Center Drive, New Windsor, New York, on Monday, September 12, 2016, at 9:30 a.m.

Yvette Arnold,

Court Reporter

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

DR. PAMELA MURPHY,
Committee Chair

DR. DAVID STUHLMILLER,
Helicopter Subcommittee Chair

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,
Director

HEALTH ALLIANCE OF THE HUDSON VALLEY

DR. GUTMAN,
Director

NORTHERN DUTCHESS HOSPITAL

DR. WILSON,
Director

NYACK HOSPITAL

DR. WILLIAM GREENHUT,
Physician Representative

ORANGE REGIONAL MEDICAL CENTER

DR. VOHRA,
Director

DR. ROANTREE,
Physician Representative

MID HUDSON REGIONAL HOSPITAL OF WMC

DR. BERKOWITZ,
Physician Representative

WESTCHESTER REMAC LIAISON

DR. ERIK LARSEN,
Physician Representative

ALSO PRESENT:

MATT NOLAN
DAVID GRASS
MATTHEW BRENNAN
MICHAEL MURPHY
ERNIE STONICK
JOSEPH SOLDA
MICHAEL BIGG
NICK GARDINER
BERNADETTE CEKUTA
KEVIN GAGE
RICHARD ROBINSON
SAL MAURO
ROBERT STACK
DAVID VIOLANTE
ISRAEL KNOBLOCH
SHARON FRAZIER
MICHAEL BENENATI

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DR. MURPHY: Welcome. Thank you everybody for coming.

We will bring the meeting to order.

I'd like to say 15 years ago yesterday was my first SEMAC meeting in Albany so I know where I was on September 11th.

I would like to formally have a moment of silence in the room for all of our lost and all the souls we put to rest that day. And just to remark that we have gone on and become strong and we are a unity that in New York State that has superseded anybody's expectations.

I would like to have a moment of silence.

Thank you all very much.

To bring the meeting to order I would like to start with a review of the minutes.

And, Dr. Roantree, what was the correction? Do you remember?

DR. ROANTREE: For the protocol, not the minutes --

DR. MURPHY: Oh, for the protocol, not the minutes?

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Anybody have any additions, completions -- any kinds of corrections anything for the minutes or can we make a motion to accept?

DR. MAO: Motion to accept.

DR. MURPHY: Thank you. Do I have a second?

DR. BERKOWITZ: Second.

DR. MURPHY: Thank you. We will accept the minutes as written.

Under old business, one of the things that we have been working on in the office is to track and to look at the utilization of Narcan in our area. As we had mentioned the last meeting, we rose to number one in Orange County as the number one area of deaths from opiate overdoses in New York State, if you can believe that, but it's true.

So I'm going to turn this over to Bill. He has the statistics of everyone that has applied to use Narcan and we are hoping to get the word out there to get more people on board.

MR. HUGHES: In the last two years we

have had substantial growth in the reportage of Narcan usage. In 2014 we had 763 uses that were reported to us within our region. And 2015 we had 824. So far this year, 2016, we have 690 and it's projected to be about a thousand if it keeps at the rate we are going. When you look at it it's 2 per day in 2014, and it's 2.25 per day 2015, and it's almost 3 per day in 2016.

Our office is a citizen based organization that distributes Narcan to any agency within our region, either fire, EMS, or -- well, fire and EMS. If anybody is interested, it's distributed free. And so far this year we have given out 592 doses, it looks like we will be giving out about 900 doses. I have it in the office, it's available, you just have to sign up for the program and report your uses. All right?

MR. LAMARCA: These are just from EMS, fire --

MR. HUGHES: Yes.

MR. LAMARCA: We don't have police figures?

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MR. HUGHES: I do not have police figures, no. They go under -- yeah, and they don't send me those.

The other thing that is kind of -- I would say depressing to me on this -- we are the first responders there and we have a substantial amount of agencies in each county that are not carrying Narcan as far as we know.

In Dutchess County we have two, four, six, eight, nine, ten agencies. In Orange County, which Pam mentioned has reached some heights, we have two, four, six, seven agencies that aren't carrying Narcan. In Putnam, we have five. In Rockland, we have six. In Ulster, we have three. And Sullivan, we have six.

So I don't know as a MAC if we want to do anything and try to insist that they carry it, but I think it's something that they should have especially with no cost to them.

MR. BENENATI: Are those numbers who do not carry or --

MR. HUGHES: Do not.

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DR. MURPHY: The last ones per county do not, that we know of. They would have to apply and have the paperwork through the office.

However, one of the things I was thinking, and you guys can let me know, we can send a notice to each one of these entities since we have the names and just remind them of the importance of carrying Narcan and the saving of lives this way. Not that I think we have to propagate people using heroin and such, but I think we have to be able to be there and be ready. And it literally is a life-saving intervention as you all know. And so it might be nice from this body we can send a letter and just remind people.

DR. STUHLMILLER: I would like to send a letter to the medical directors asking them --

DR. MURPHY: Yeah, why they don't -- well, some of them will be -- like Millbrook Fire do they have a medical director?

MR. HUGHES: Yes.

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DR. MURPHY: Okay, so --

DR. STUHLMILLER: Challenge the doctor to make that happen for the community.

DR. MURPHY: Yeah, and they may not know. Some of these guys are very removed from their places.

MR. HUGHES: We have tried to work through the county coordinators, they have tried to, you know, stimulate these people. We will work through the agencies, but this is what we have left, it's been uphill --

DR. MURPHY: -- we will make a recommendation to send to the medical director and send a letter from the REMAC stating, you know, the importance of it and can we get them on page. And remind them that we do distribute and being a public interest we have been trying to be there for people and --

DR. VOHRA: Maybe send them the application.

DR. MURPHY: Yeah, attached. Thank you.

DR. VOHRA: And envelope as well.

DR. MURPHY: Yeah, stamped, sealed and

self-addressed.

DR. LARSEN: You don't have the figures for Westchester County offhand?

MR. HUGHES: No --

DR. MURPHY: There is that report that came up. Where did we get that from? I can send it because I still have -- it was pretty crazy --

DR. LARSEN: I don't have --

DR. MURPHY: I can't remember where I had it. I must have had it on --

MR. HUGHES: Is this the report you are looking for?

DR. VOHRA: The numbers are so much larger than what the numbers you have because you are just getting them from EMS.

DR. MURPHY: Oh, yeah. Police have a tremendous usage, this is just a small part of the equation.

Okay, evaluation subcommittee report, Dr. Arshad?

DR. ARSHAD: Good morning. We had one PCR submitted for review since the June session. It was in regards to a 20 year old

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driver restraint who hit a pole and had a rollover event, was extricated by bystanders on scene and was self-ambulating. BLS was first on scene, and that was East Fishkill Fire Rescue, and there was also a dual response with ALS and Mobile Life unit arrived shortly thereafter.

Upon the primary and secondary survey the patient had essentially normal vital signs. Dr. Murphy did notice there was a typo in the PCR with a diastolic blood pressure of 782 --

DR. MURPHY: I just thought it was a little high, it caught my eye --

DR. HILL: Especially diastolic --

(Everyone is speaking at once.)

DR. ARSHAD: -- the patient had benign exam and a GCS of 15. ALS released to BLS and upon the patient's request to be specifically transported began transport to Putnam Hospital. Called the report in to the charge nurse, who asked them to redirect to a trauma center, which they did not feel was appropriate especially since the patient had

normal vital signs, despite the proposed mechanism. And was transported to Putnam.

We thought their care was appropriate. And after a follow-up the patient had been evaluated at Putnam, had no other gross injuries identified and was discharged from the hospital.

DR. LARSEN: How old was the patient?

DR. ARSHAD: Thirty -- sorry -- twenty.

DR. MURPHY: Thank you.

Helicopter committee report, Dr. Stuhlmiller?

DR. STUHLMILLER: There has been no business before the committee so I have nothing to report.

DR. MURPHY: Okay, that makes it easy.

RTAC, Dr. Berkowitz?

DR. BERKOWITZ: I'm trying to figure out when the next meeting is. I don't think we had one since the last one, have we?

DR. MURPHY: No --

MR. HUGHES: October, I think.

DR. MURPHY: -- SEMAC is tomorrow, our reports are --

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DR. BERKOWITZ: Nothing new to present.

DR. MURPHY: Quality improvement, Jeff?

MR. CRUTCHER: Image Trend is in the process of giving us our new Elite Bridge for Nemesis 3. There were some growing pains last year with that bridge. Image Trend pulled the product back to fix the bugs. At this time too what we were waiting for was the new data dictionary release from New York State. We do now have a draft copy of that. We should be able to finalize that in the next couple weeks and start moving the agencies that are Nemesis 3 compliant over to the new bridge.

DR. MURPHY: Awesome. That's very good because that will make -- we will just be able to require so much more information and have so many more substantial things to look at.

Protocol committee, Mr. Benenati?

MR. BENENATI: Actually because of the State meeting also -- but the collaboratives were approved. At this point we are waiting for training documents and meetings tomorrow

to find out how it's going to be rolled out and when that will be rolled out. I would anticipate that we probably wouldn't be able to bring it here until January 1st. And that maybe the best way to do, if not later than that.

Dr. Papish is also working on an advisory based on the previous discussion with regards to pediatric trauma getting to the appropriate trauma centers and we don't have anything on that yet, it's still an early draft.

And that's all we have at this point.

DR. MURPHY: So for timeline, we are going to vote on the protocols as they stand for right now. We just have to notify SEMAC because they have been approved that we you know go forward depending on what the group decides today. And then with the roll out probably through the end of the year we can start January timeline.

MR. BENENATI: I mean, it's still a lot of work between now and then.

Dr. Arshad, have you made any progress

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with --

DR. ARSHAD: We have some updates in regards to the trainings. So some regions have taken condition the liberty and leadership to start developing some of the trainings associated with the new collaborative protocols roll out.

And I just want to acknowledge Dr. Murphy and her -- she's built a module on end of life care and prehospital implications associated with that for all New York State providers, which will be reviewed tomorrow at SEMAC after the meeting -- early afternoon meeting.

Dr. Cushman, I think, of Rochester, is also developing some training materials, which we hope to review as a body and sort of do a peer review and begin to share with all the individual regions so we don't have to duplicate all of our efforts.

Then we have been asked by some of the State leadership --

(The speaker cannot be heard.)

DR. ARSHAD: -- to host the Hudson

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Valley -- to host the simulation training required for the new protocols. And specifically they want us to do a difficult and challenging airway with a task trainer, a neonatal resuscitation, as well as a double sequence defibrillation and refractory ventricular fibrillation, and lastly, complicated obstetrical deliveries and -- crash deliveries, in other words.

So we have been in touch with our colleagues in Wappingers Falls, the Laerdal folks and we are now determining dates in mid November for leaders from all across the State to come to Wappingers, where we will have scripts and detailed scenarios and we will record them. And hopefully they preliminarily dedicated some video editing resources so it should be fairly high-end and, I think, an excellent contribution from the Hudson Valley to the rest of the State.

DR. MURPHY: That's a great setup.

DR. ARSHAD: Yeah, if folks are interested -- and I know Mike and Dave, Sharon, obviously anybody is invited. We

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will be -- I volunteered them --

(Everyone is speaking at once.)

DR. ARSHAD: -- so we will hopefully be able to choose a date, so just be in touch with Mike and we will coordinate the dates and make sure everybody that wants to be involved has an opportunity and represent the Hudson Valley at State level.

DR. MURPHY: Thanks. So that's pretty much it from -- well, we have it under new business, talking about utilization of residents for medical control.

MR. BENENATI: I'm not in on that conversation --

DR. MURPHY: Oh, I thought you guys -- so I thought you guys were part of that.

MR. LAMARCA: It's new business.

DR. MURPHY: It's listed under new business. Sorry, I thought it was a good segue.

So to utilize residents as qualified to man the radio and take the conversations in terms of medical control contact with our providers. We were discussing it because in

the past we have had institutions that requested physician assistant and nurse practitioner that were in the emergency department to be able to do such. And so we pulled up under our control plan the definition and qualifications of medical control to look at and see is it something moving forward that we could do? Orange Regional now has residents and I'm sure other institutions attached to Westchester in our facility will be having residents so it was an issue of -- I'll pass this around, Eric.

DR. LARSEN: Sure.

DR. MURPHY: That's the basic tenants of what -- the excerpt is from our medical control plan of really how does a person qualify to be MAC certified and man the radio? And to me it's pretty straightforward the residents should be able to do. The only thing we have to do is make them take the MAC exam, like everybody else, and that they have the ACLS and Powell's, which they do. And going forward would be another way -- there is quite a bit of interest actually in the

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residents of and wanting to do EMS and such and -- Arshad, they would love to have a fellowship up here in EMS, just hint hint for the future.

And it's a thing where, you know, I think the response is kind of overwhelming.

Dr. Roantree, any comment?

DR. ROANTREE: No. I think that's a great idea. It should be incorporated into the training at Orange since we have 10 emergency medicine residents now and it should certainly be a part of the training.

DR. MURPHY: This is why I am sending it around to you. We have to look at -- the only place it becomes an issue is they have to be a New York State licensed physician on our criteria because we never had residents up until now.

So I wanted to bring this to protocol to look at and could we reword it to the extent of or a certified resident, or however we want to verbalize it. Because you can't get a New York State license until you practice and so the first years are not going to have

one. So that was the one place that made them fallout. However, I thought we could push it forward to bring to protocol and to this body of a recommendation. I thought the residents are definitely someone we should get involved early, get them -- you know, in the process, learn the protocols, learn the whole procedure of how it's done and that was the one sticking point there, the definition of qualifications.

Any comments?

DR. HILL: I think it would be reasonable to say, for instance, license eligible so that interns weren't giving medical direction, but after internship --

DR. MURPHY: Andy?

MR. LAMARCA: Just a suggestion how to phrase it, residents approved by the medical director -- the medical director of the medical control facility, that way you know he or she would be authorized.

DR. MURPHY: And, also, they would know them well so that it could be, you know, under --

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DR. LARSEN: Well, know them --

DR. MURPHY: Yes.

DR. MAO: Are we talking ER residents or all residents?

DR. MURPHY: No, ER residents.

DR. VOHRA: My training -- in my training for residency answering EMS phone was part of your role, you know, year two and three so --

DR. MURPHY: Yeah, we had to become familiar with the protocols, we had to ride -- when are these guys riding?

DR. VOHRA: I'm not sure.

DR. MURPHY: The only time ever in my life I got car sick in the back of an ambulance and I don't get car sick at all --

DR. VOHRA: It's that smell.

DR. MURPHY: I don't know, it was horrible. People talked about it, but it was pretty --

DR. HILL: It's hard to keep your eyes on the horizon from the back of the ambulance.

DR. STUHLMILLER: No ride along with us

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for you then --

DR. MURPHY: I did that in Grenada.

So what we can do is if anybody has any strong opinions against or such, I'll bring it to the protocol committee so we can look at verbiage. And maybe a good suggestion, as Dr. Hill just said, is license eligible practitioners, or we could also have it be the medical director signs off on it. We can look at both those things. I think it's an integral part and we need more and more people involved in prehospital and EMS and it's just a great start for them, I think, that interaction. And just them giving the report to the residents, them taking the report is all very much part of their training.

Any other comments?

DR. GREENHUT: Did you allude to NP and PA also?

DR. MURPHY: In other areas they have asked for that. Vassar was one, you know, because they are licensed practitioners. It -- you know, that's where it started years

ago. They had felt that they had more stability with some of the practitioners being there than the Locums so to help out they had asked for that.

DR. VOHRA: And there are sites that already have --

DR. MURPHY: Yeah, if you look at Ellenville, they are not medical control, but there are places, Callicoon.

So the most important thing under new business and I --

MR. BENENATI: Just point of order, you mentioned that you wanted REMAC approval on the protocol. Do you need to go back and do that? You quickly said you wanted to send it up to State --

DR. MURPHY: No. We are doing it right now.

So the most important thing of this meeting -- and thank you everybody for taking time, I know it's not easy to make it to these meetings sometimes and this morning is a great attendance -- really thank you, thank you, thank you.

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So what I'm bringing forward is the 2016 collaborative protocols, we sent them out. The only thing that has been added since I sent them out was a protocol I wrote on end of life. It doesn't have much, it just says when do you not want to resuscitate somebody? I explained all this stuff about end of life decision making what DNR and EMOLS (phonetic) and MOLS (phonetic) forms themselves are all about. It was pretty straightforward, to me, it's not really a protocol, but we needed something in there. So that was the only addition since you had seen my -- I sent it out -- and tell me the typo?

DR. ROANTREE: It's really silly, on page 10 -- do you have it in front of you?

Sentence under key points says if the cardiac monitor is shows, confirming more than one lead. I presume they mean --

(The speaker cannot be heard.)

DR. MURPHY: We are missing a very important word there and it's crazy how many people looked at that and you still can find things of that nature.

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So I want to put out a proposal, if I could have a motion to accept the 2017 collaborative protocols for our region?

DR. ARSHAD: Motion.

DR. MURPHY: And second?

DR. WILSON: I'll second.

DR. MURPHY: Second from Dr. Wilson, thank you.

All those in favor with a hand raised?

Great, thank you. So it's unanimous.

Under protocols, thank you everybody. One of the agencies in our region, New Windsor, is going to put forth from their medical director an addition of ketamine to their formulary. They are going to be the first agency that has put it on their formulary in this area. They sent it me a nice letter from their medical director and I just want to bring it forward that it will be the first agency to utilize the medication and add it to their formulary. If anyone wants to see the letter from their medical director and his assurance of utilization and oversight, I can send it to you, but it will

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be the first agency to do so.

And we welcome them here today -- where did you guys sit? You are hiding on me.

They really did a lot of nice work and they also brought forth a notification that they were recognized by American Heart Association for a silver award for one of the EMS agencies that followed and met all the criteria for acute MIs in the field; i.e., all the issues of how fast the EKG is done, how is it transmitted, the patient arriving at the scene, and meeting all the criteria that American Heart Association has for a mission for recognition of MIs in the field, so kudos to New Windsor.

I'll turn it to over to Bill for Danbury Ambulance CON.

MR. HUGHES: Just so you are aware, the Danbury Ambulance Corps applied to operate within our territory in the counties of Putnam and Dutchess. They have brought in their application -- or submitted their application. We have had a public hearing. We have had a response from our Hearing

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Officer. We are waiting for the transportation committee to come up with a recommendation so it's possible there could be a recommendation they do come in. Some of it is pointing towards the negative, but they didn't prove need. But at this point we have to wait for the vote at the next REMSCO meeting.

DR. STUHLMILLER: What level of care do they provide?

MR. HUGHES: They were planning on ALS level. Every CON comes in BLS and then upgrades, but they were planning ALS level.

Also, the second one we have coming up is TransCare. As you are aware, TransCare went bankrupt several months ago. Their CON has been purchased by a company called Ambulanz, A-M-B-U-L-A-N-Z, New York 2, that would be the company that will now own them. They have submitted their paperwork for the transfer of ownership and it was deemed complete and sent to New York State. And we are waiting to get fitness and competency back from there and that will also be at our

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REMSCO meeting next month.

That's it on the two we have coming in.

DR. MURPHY: I like the name. They are actually California based, they do have a company in California.

MR. HUGHES: Also, from what I understand there is three other CONs they have purchased and are in the process of getting them, one Nassau, one in Suffolk and one for the five boroughs of New York. And then with ours it would be our six counties plus Westchester and plus Delaware County so the whole section.

DR. MURPHY: Okay. SEMAC report.

We haven't had a meeting, it's tomorrow. So sorry, these reports are pretty short and concise. But I'll bring back everything to our meeting in November.

Under PAD, Epipen, Albuterol glucometer, we had no one apply since the last time.

But I have a few announcements to read into the minutes.

Glenham Fire District has until august 31st to update their Epipen program and they

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received a notice from New York State Department of Health.

Wassaic Fire Company has received a notification that they are no longer -- their agency code that was previously issued to them is no longer active and may not be used on their PCRs or ambulance care reports. Their certificate and operating authority cannot be reactivated by your entity and they have to reapply and this is under Article 30 of Public Health Law.

Jean Fontus from Brooklyn, New York has been censured and assessed a civil penalty of $2,000.00 for violations of Part 800.

And Michael Schwertfeger from Fredonia, New York has been suspended. The suspension will be served in concurrent with the last day of employment, October 11th. And he is assessed a penalty of $1,000.00.

And, lastly, Ziph Hedrington from Bronx, New York has been suspended for one year for -- assessed a penalty of $2,000.00, again for a violation of Part 800.

We have been sent around a -- under open

forum, just some updates. We have been sent around a notification of you know, ongoing list of drugs and inability to get certain medications, both from a perspective of not being manufactured to just not being available.

As you know, there is a huge discussion now with the company that produces Epi-pens, and the government is looking at how the cost of the Epi-pens went up so dramatically. The State put out its final report on Epi-pens and inject program and so that will probably move forward it's been placed to the department and to see what the viability of the program is.

So under new -- or open forum we had sent around a list of the meetings for next time.

MR. HUGHES: Can I just interrupt for one thing? On the Glenham Fire District, they are in good standing until 2009 (sic). The only thing they mentioned with Epi is if they change. So they are an agency that is in good standing. That's all.

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DR. MURPHY: Okay. So one comment was made for January 2nd, we have question marks next to a couple of dates here. So I was thinking maybe we could move that down to January 9th. January 2nd is so close to the holiday people might be away. January 9th, if that works out better moving it one week away.

And then I think September 11th there is so many things that go on that date, let's move it to the following week. September 4th is Labor Day so we can't have it that day, but if we move it to September 18th I know it's later on in the month, but it will be after SEMAC and so might be more advantageous and profitable to get things done and move things forward.

So I would say if people want to look at it and make suggestions they would be my two suggestions for the date changes. The other dates seem to be okay. It should be in your packet it was out front to look at --

DR. LARSEN: So we are talking -- what are the two date changes?

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DR. MURPHY: So I was thinking January 9th. Monday, January 9th for the first one. And March 6th is the second meeting. June 5th is the third. And September 18th instead of 9/11. And the last one being November 6th.

DR. LARSEN: Okay, just because we may have some conflict with Westchester County, but I think we can work that out.

DR. MURPHY: Similar dates?

DR. LARSEN: Yeah, because we usually go a week later.

DR. MURPHY: Oh, so I might be popping into your dates --

DR. LARSEN: Yeah, well, whatever, we will look at it.

DR. MURPHY: Then under open forum, anybody have anything they need to discuss this morning?

MR. GARDINER: Nick Gardiner, New Windsor. When we talked last week about the --

(The speaker cannot be understood.)

MR. GARDINER: -- our protocol was

written by your medical director, there were certain circumstances, MFI and excited delirium, where we'd like to be doing it without calling for orders, you said you wanted to put that to a vote before we went ahead and started doing that --

DR. MURPHY: I have to bring it to protocol committee, but I put it out for everybody in look at.

But one of the things to do is, first of all, you can absolutely use it within the protocols we accepted here today, so moving forward. The two things of having it to go without contact is something we'll have to bring to protocol and have everybody look at. But the acquisition of it and utilization in the protocol as it stands now is absolutely cool.

Andy?

MR. LAMARCA: Nothing about that now, if that's done I have --

DR. MURPHY: Okay. Is that good?

MR. GARDINER: Yep. Thank you.

MR. LAMARCA: Just I know for many years

most of the emergency rooms have had a plan with transfer of patient where blood is running. For years we laid at the foot of the Department of Health and, you know, certainly the division of labs, and obviously that's changed. So we -- although it is possible for us to do with proper training and credentials, which we have gotten, and we have had feelers out to many hospitals, right now only Mid Hudson Regional has completed what we need to for us to do that legally. We are still doing it in some areas underneath the same self-report system we had to use to do this in the past. But I really urge the medical directors to take a look in your hospital if it is being stalled by -- usually the director of your blood bank, you know. But we are not moving forward, this should have been done at almost all facilities by now and it's not. So if you can give it a little jump start. In some of the same facilities where we are tied up we are still doing blood transfers and that's something, in all fairness, we shouldn't

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worry about --

(Everyone is speaking at once.)

DR. LARSEN: If you could get us the template for this because our blood bank is willing to do it, but it seems -- I mean, we -- and Jonathan were looking at it, we haven't accomplished it, right?

DR. BERKOWITZ: Yeah.

DR. LARSEN: It complicated.

DR. MURPHY: Yeah. And I think because it's already been done and they had it go through the system it gives people, and especially the blood bank, which has never crossed this bridge, some security because it's all setup and it's been successful. And the Mobile Life applied through the State and had all of the information and protocols in place. And so it's there, it's done. So I think it's a thing that behooves every trauma center, every receiving facility to get on board because it is a matter of if you are transporting with blood it's actually against the law unless you really have this entity in place. And we have done it in the past, I

did one when I first got here and pretty much wrote up, you know, the patient is going to die without it. He was a leaking triple A and we didn't have vascular surgery back then. So it's a thing where the State has finally put through the blood product transportation protocol we need to utilize and it get out there and have people stepping up to the plate.

MR. LAMARCA: Matt Brennan is here tonight. He was one of the program directors so specific questions he can.

DR. VOHRA: This is difficult to do on the hospital level because the director of lab made it seem like --

MR. LAMARCA: Most of our discussions seems like they are ill-informed of changes and we have met the requirement and training requirement. So, again, we'd be more than happy to attend meetings with whoever you want, in addition to that --

DR. VOHRA: Okay.

MR. LAMARCA: They seem to have a disconnect between what the needs of the

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hospital to the transfer --

DR. MURPHY: And that the State approved it, I mean that's the other thing that is so remarkable. They took a long -- Andy, how long was it? Ten years.

MR. LAMARCA: That they have been on with that?

DR. MURPHY: Yeah.

MR. LAMARCA: Well, spinal was 10 years, I think this might have been more.

DR. MURPHY: It's really been a long time. And finally it came off the desk of the Department of Health and DOH approving it so the process is there. I think it's more educational, that they just don't realize so --

DR. MAO: We are almost ready to setup with this. It's a much bigger process than you think because it's not just ED that sends a patient, it's the whole building. It requires all of nursing and entire building on board so not just lab. You have to get nursing involved before the transport out, any other division, whatever size it is, they

have to go through as well. So it's a whole hospital project, system wide. So we are going to send ours to legal relatively soon and we have the nursing side on board as well. It's a lot more work and it would be easier to get the hospital setup, it moves slowly.

DR. MURPHY: Well, the one thing -- correct me if I'm wrong -- was -- or Matt, either one -- it was setup such that the blood will be tagged and hung and signed off on at the hospital and so it's running as you are going. You are not going to put up a new unit in route so that makes a big difference. So that you have your setup of two people signing off on the unit of blood and documenting, you know, this is the unit for this person and it's hung and they transport with it. They are not taking another unit to hang by themselves. So that makes a big difference in help for the logistics of it.

DR. VOHRA: The feedback I got was it's very complicated and since it's just a small volume of patients -- we are going to move

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back --

(Everyone is speaking at once.)

DR. MAO: The whole nursing side has to be involved and the different departments, that's another hold up. Again, you are right, it's much easier if it's started in the building.

DR. MURPHY: Yeah, that's one of the things to facilitate that would work easier.

DR. MAO: Whatever, whether they are hung or whatever, it still has to get to the nursing staff.

DR. MURPHY: Yeah. That's it?

Anything else under new forum?

MR. BIGG: Michael Bigg from New Windsor Ambulance. We have had a lot of requests from law enforcement to draw bloods, crime scene or DUI, and there is no protocol out for us to go off for drawing blood for law enforcement that we are not transporting. We have seen memos and stuff from DOH in the last years, there is no clarification so providers have concerns about protocol, documentation, how to do an RMA. Our town

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wants us to do blood draws and we want some clarification on --

DR. MURPHY: Our opinion has always been -- no. You know --

MR. BIGG: He said they can order us to do it so it's a bad area, if they say no, we are not doing it so we just want to know --

DR. MURPHY: They are not our oversight. What are they are going to do, arrest you and take you with them?

We have always been on the side of no because it puts you in a very precarious position. And it's just -- we have gone back and forthwith this many many times because it has come up --

MR. BIGG: Can we have an official region -- that says we are not letting our providers in the Hudson Valley do this? Is there a dated memo that says that I can get a copy of?

DR. MURPHY: It's a been a long time -- when did we do that?

DR. STUHLMILLER: Years ago, I remember discussions it.

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DR. MURPHY: It's been a thing that is -- was discord -- and no. So I'll put myself a -- we will look that up for the original -- but it's like years.

DR. STUHLMILLER: I seem to remember a discussion that a legal contract could be drawn for the law enforcement entity to the medical prehospital entity with an agreement that you will respond and draw blood with the appropriate indemnification and all those legal aspects is the only really way to do that.

MR. BIGG: There is a law in New York State that indemnifies the paramedics now that states the law -- we are just getting a lot of push back from law enforcement --

(The speaker cannot be heard.)

DR. HILL: Do you want to do it?

MR. BIGG: I don't want to do it, but they keep pushing us to do it.

DR. MURPHY: So we have it, it's from 2010 so I'll make sure we get it you guys.

MR. BIGG: Okay.

DR. MURPHY: Any other new business in

the open forum?

DR. LARSEN: I mean, this is more for the RTAC and stuff. But does anyone have any idea where the State is going with its designation of trauma centers, I mean --

MR. VIOLANTE: I mean, we just got the blood issue done.

DR. LARSEN: I mean, are they going for every hospital to be some level, or I mean how is this going to be spelled out to us? Because it's sort of like it's out there and people are still not sure where to go.

DR. BERKOWITZ: It seems to me that they haven't from -- my understanding is any hospital that wants to try, but they have the bar pretty high. So if you want to try you do get kind of two years to try your trauma head on and see how you like it. And if you don't like, you know, how much it costs and how much work you have to put you can just toss it off. But the State hasn't said -- I never heard anyone say there is a specific plan of where and who as much as it's just kind of said that, you know, we want the

hospitals to -- that want to do it, to do it.

That's my understanding. Does anyone have a different understanding?

DR. MURPHY: The only thing that ever came up in our auspices was the State was looking at that there was really no real good boundaries between Westchester and Albany and that's why they were pushing Orange Regional to please take a foothold in getting a designation for trauma care.

But like Dr. Berkowitz is saying, it's a two year provision kind of thing to get your ducks in a row and decide whether you can do it or not. Initially Orange Regional had applied for a level three and they had asked them to -- encouraged them to be a level two, but that's the only one I've ever seen. I've never seen anything in writing or any major plan for --

DR. VOHRA: Like you have to have certain docs on staff, specialists --

DR. MURPHY: Oh, yes, it's all criteria.

DR. BERKOWITZ: The bar is relatively high --

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DR. LARSEN: Yes, it is. It's ACS bar and review --

DR. VOHRA: We can say we want to be a level one, we --

DR. BERKOWITZ: You could, but that would have been the --

(Everyone is speaking at once.)

DR. MURPHY: Any other issues?

I have one thing I need to bring up just to make you guys aware.

So as I mentioned my first SEMAC meeting was 2001, so that is 15 years ago. I'm just as old. But so I was doing this even before that so I just want to make sure you guys still want me in this position and that, you know, you are not sick of listening to me yet.

I have as of May 1st changed my position at Orange Regional. I'm no longer practicing in the emergency department, so that's an issue that you have to feel comfortable with still having me in this position. I am administration at the hospital now. So it's moved me into a position of oversight of all

care in the hospital not just ER, it's everywhere. So I still am involved in a lot of it. I still teach, I still do the residency education and such. But just because I'm not a hands-on emergency department physician anymore I want to make sure that is out and known. Because absolutely you can make a recommendation to the REMSCO to have me replaced. If that's -- you know, if I don't meet the criteria for people. But I wanted to make sure that's on board and everyone is aware I changed my status, 25 years of running around the ER was enough for me.

So just FYI and if people want to make recommendations, it's not a problem and it goes through REMSCO, that's who initially hired me so long ago. But just food for thought and if it's something --

DR. LARSEN: What does our mandate say?

DR. MURPHY: You have to still be practicing, they want you involved in emergency medicine. It doesn't say you have to be running around the ER. It's more so of

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a problem with medical directors of agencies, we like them to be involved in emergency medicine also, so that's where it's really written in black and white.

Any other new business?

A motion to adjourn?

DR. LARSEN: Do we need a vote of confidence?

DR. MURPHY: You know, you guys, I don't know if you need a vote of confidence, but people can definitely step up if anybody wants to do it. I know that there is Dr. Papish -- who is not here and cannot speak for himself -- but Mark has stepped up to become medical director and work with us so new faces, new blood, new eyes, it's all good stuff. Some of you have had to listen to me for a very long time -- Dr. Wilson and Dr. Larsen -- you have been here just as long. So, you know, I just want to make sure I am above board with everybody in what is going on.

Any other -- motion to adjourn?

DR. VOHRA: Motion.

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DR. MURPHY: And second?

DR. WILSON: I'll second.

DR. MURPHY: Thank you everybody.

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

Yvette Arnold