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HUDSON VALLEY REGIONAL EMERGENCY

MEDICAL ADVISORY COMMITTEE

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MINUTES OF MEETING, held at the offices of Hudson Valley Regional EMS, 33 Airport Center Drive, New Windsor, New York, on Monday, November 7, 2016, at 9:35 a.m.

Yvette Arnold,

Court Reporter

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DR. DAVID STUHLMILLER,
Helicopter Subcommittee Chair

DR. ARSHAD,
Evaluation Subcommittee Chair

WILLIAM HUGHES, EMT
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DR. MCGINLEY,
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DR. BUTTERFASS,
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MID HUDSON REGIONAL HOSPITAL OF WMC

DR. PAPISH,
Director

DR. BERKOWITZ,
Physician Representative

VASSAR BROTHERS MEDICAL CENTER

DR. ARSHAD,
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A P P E A R A N C E S :

DAVID VIOLANTE
MIKE BENENATI
MICHAEL CASO
MICHAEL MURPHY
MATTHEW BRENNAN
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ERNIE STONICK
RICHARD PARRISH
DAVID GRASS
ISRAEL KNOBLOCH
JOHN MAHONEY
MATT NOLAN
KIM LIPPES
SHARON FRAZIER
WILLIAM JEFFRIES

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DR. MURPHY: Let's bring the meeting to order.

Good morning. Thank you for coming. We will bring the meeting to order.

First on the agenda I would like to -- we need to pass around -- do you want a roll call?

MR. HUGHES: Roll call would be easier.

DR. MURPHY: It's easier -- Pamela Murphy, Chair of REMAC.

DR. PAPISH: Mark Papish, Medical Director, REMSCO.

DR. McGINLEY: Trevor McGinley, Associate Director, ORMC.

DR. STUHLMILLER: David Stuhlmiller, Chair of the Helicopter Committee.

DR. MURPHY: It's going to be the last time --

DR. BERKOWITZ: I have some tissues.

DR. STUHLMILLER: We are in for a big party.

DR. MURPHY: No, don't say that. How long has it been, five years?

DR. STUHLMILLER: Eleven.

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DR. MURPHY: No, but you were doing life -- that's only five, isn't it?

DR. STUHLMILLER: Eleven years, 2005.

DR. MURPHY: Time flies when you are having fun.

DR. BERKOWITZ: Jon Berkowitz, representing Westchester Medical Center and also the Westchester REMAC.

DR. MAO: Dennis Mao, Good Samaritan Hospital.

DR. MURPHY: Richie?

MR. PARRISH: Rich Parrish, President, REMSCO.

MS. DELAUNAY: Karen, hello -- Kim Lippes.

DR. MURPHY: No, I am getting to the back of the room, don't worry.

MR. VIOLANTE: Dave Violante, Chair of Training and Ed.

DR. KWON: Johnny Kwon, Nyack Hospital.

DR. GELLER: Barry Geller, New York Presbyterian, Hudson Valley Hospital.

MR. CRUTCHER: Jeff Crutcher, QA QI coordinator.

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DR. MURPHY: Okay, great. Back of the room, Michael?

MR. BENENATI: Mike Benenati, Protocol Committee Chair.

MR. CASO: Michael Caso, C-A-S-O, LaGrange.

MR. MURPHY: Mike Murphy, Rockland Paramedics and Council delegate.

MR. ROBINSON: Richard Robinson, New York State EMS.

(The speaker cannot be heard.)

SPEAKER: -- Emstar.

MR. JEFFRIES: William Jeffries, Regional Faculty and Mobile Life Support.

MR. BRENNAN: Matthew Brennan, Mobile Life Support.

MR. CARPICO: Guy Carpico, Vassar Brothers Hospital.

MR. STONICK: Ernie Stonick, Good Samaritan Hospital.

MR. LEIDNER: B.J. Leidner, Hatzolah Rockland.

MR. KNOBLOCH: Israel Knobloch, Kiryas Joel.

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MR. MAHONEY: John Mahoney, Dutchess EMS coordinator.

MR. GRASS: David Grass, Mobile Life Support.

MR. GAGE: Kevin Gage, New York State Department of Health.

DR. MURPHY: And Dr. Butterfass just came in.

Thank you, everyone. It's always good to do that everyone once in a while so everyone gets a name with a face.

I know we have big busy lives, thank you for taking the time to come this morning. It's important we sit in a room together and make sure we disseminate all the information, we bring forth everything to each one of our facilities. We all come from institutions that are prior to the process and we all have to do this together -- and I don't mean to like a politicians.

Let's review the minutes from September 12th meeting, they were sent by Karen. Any additions, deletions, or corrections?

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You did good, Karen.

Any exceptions to the minutes?

DR. PAPISH: Motion.

DR. MURPHY: That's what I'm saying -- motion to accept.

DR. BERKOWITZ: Second.

DR. MURPHY: Thanks, guys.

So under old business -- I'm hoping Dr. Arshad shows up, if he can't, I'll try and fill in everything.

But were they given the rollout draft?

MS. DELAUNAY: No.

MR. HUGHES: No.

MS. DELAUNAY: Do you want them to --

DR. MURPHY: Yeah, could they have it?

One of the docs in the protocol committee asked for was like a little synopsis of all of the things that were different in our protocols this time coming out. And, again, they are listed here with -- they are mainly a lot of corrections. But the protocols that were really changed and the biggest topics were of four categories under end of life, Ketamine, patellar

reduction, and calcium.

What has been setup is Dr. Arshad, working with Dr. Fullagar from Upstate, are going to November 21st -- and if people are interested I can give you an e-mail address to sign up for it at the Laerdal Center in Fishkill. And what we are going to do is devise a pod cast video program for all the rollout. And what will happen is it will bring forward all the new policies and corrections, emphasize these new protocols, even though it's really only patellar reduction, end of life. But we will talk about a few other things, how BLS will integrate with ALS and how the importance of the BLS first steps are and they have a few other things they are going to put in there. It will be a video demonstration and that way we will be able to broadcast to everyone and everyone can use it at their respective hospitals and agencies to update everyone for the 2016 protocols.

We had submitted an approval letter after our last meeting here to SEMAC stating

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that we voted to approve them. We have not received back the confirmation from them, but it should be just a matter of Andrew Johnson writing a letter. Neither here, nor there, we are moving forward with the rollout process.

Mike, you want to say anything?

MR. BENENATI: There is just a lot of things happening with this process. One of the things that we as a region needed to do is submit some questions for the question pool. That's going to be, again, a statewide or collaborative exam, there will be an open book component to it. And we are also looking to see if we can do that in our region on-line. Bill is exploring that as an option as part of that process.

Along with the rollout also is a number of policy items were taken out of the protocol because the protocol now focuses on patient care. The members of the Protocol Committee have been assigned those policies which were taken out so they could be developed and they will then be rolled into a

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document that will need to be adopted by this body as policy.

DR. MURPHY: And that was to keep it so that, you know, each region always has -- you know, whether it be governing issues or local issues that makes it unique, like our Hudson Valley will be different than Rochester and our Hudson Valley is going to be different than Syracuse. So the point of pulling those kind of administrative policy -- and what is the word? I can't think of the word. Those policies don't need to be part of the collaborative policies because they are going to be different from everybody else, that's why we are pulling it out and keeping the critical protocols in there so it's standardized across the board everywhere. What do we call it? Medical control something --

MR. BENENATI: So those topics for medical control, aeromedical utilization emergency incident rehab, specialty care transport, transfer of care, medication facilitated intubation and clinician on

scene. So a lot of work needs to be done yet and we are working on that and we will continue to plug along for the collaboratives. And some of us are participating the week of Thanksgiving on the filming as well.

DR. MURPHY: Let me have one of the assignments. I missed the meeting, make sure you give me one.

MR. BENENATI: Okay.

DR. MURPHY: So it's a lot of kind of pieces coming together for the collaborative protocol rollout. But I think, as you remember from last year, we had a lot of problems kind of getting the word out to everyone so I think this is a much better method to get to everyone at the same time and have the same message and be teaching the same material.

Any questions? Any concerns?

Moving on. Utilization of MAC certified residents for medical control, this is an issue from Orange Regional. And what we have done is sat down with the residents -- well,

not sat, but e-mailed the residency director and they are going to follow the same rules as we do. They will become MAC certified, take the exam, and they have to be a New York State licensed physician, thus it can only be a second year resident, you are not licensed in your first year so that will be the one change. So it will only be second years and above. And they do have second year residents this year so we are going to try and get them all MAC certified for medical control.

New Windsor and Ketamine. So New Windsor had been the first organization in our area to really want to utilize Ketamine. They got together with their medical director and devised a protocol they thought would be helpful and utilizing in their services. And it came up because they started to do some larger events, they started to cover some larger events. However, the protocol they sent to me was different from ours so I told them they have to follow ours. And the reason they didn't know our protocol is

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because it hadn't gone out, it had just been approved. I sent them ours and said as long as you follow this you can work towards getting Ketamine on board. It's up to your medical director, it's a local direction issue and utilization and they have to provide us with, any time it's utilized, documentation and such. So it still hasn't happened, but it's going to. I just wanted to let you guys know they will be the first agency to have Ketamine on board and it will be followed under our protocols.

Narcan update? I don't have anything.

MR. CRUTCHER: Narcan usage continues to grow. We are doing three to three point four administrations daily and that's only through EMS. We don't get all of the reports from law enforcement or fire departments that are not certified agencies that can use the Narcan. The State has actually created another data collection position within the Department of Health to more firmly track all of these numbers. They did that on a grant so for the next three years we will probably

have some better idea of how much is getting used. Orange County still seems to be leading the nation in heroin deaths.

DR. MURPHY: Did you realize that? I reported it last time. We never used to be, but we are number one -- keep going.

MR. CRUTCHER: And towards that end we have now got about 60 percent of EMS agencies within the region that are carrying Narcan, we would really like to get the other 40 percent on board. So as medical directors, as agency leadership, we would really like to see you follow through. This is a totally funded program, the training is free, the Narcan kits are free. And agencies should be taking advantage of this.

DR. MURPHY: And it's -- any agency you can reach out to, you know, so it's a thing where we're just trying to be an advocate in the area. We did not do this because we were number one, that came out afterwards.

We have been working on this -- thanks to Jeff and Bill -- for the last couple years and have successfully put this altogether.

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Okay -- sorry my brother from another mother.

MR. MURPHY: Mike Murphy, Rockland Paramedics. I'm also the Rockland Paramedics Opioid Overdose Prevention Program Director and we have about 500 law enforcement officers under our domain.

On Friday morning manufacturer of the nasal atomizer released a recall. The problem being is that in a select few of their nasal atomizers perhaps the hole was not drilled tiny enough and was atomizing the material, it squirts it. So, therefore, the manufacturer put an immediate recall on the device. I was in touch with folks from the agency Friday afternoon because there is the dilemma of, do we shutdown all Narcan in the State of New York because most of the atomizers are being recalled? Or are they just going to quarantine whatever was supposed to be delivered?

I guess the problem or dilemma that people are facing is some Narcan is better than no Narcan. If you totally shutdown

because the atomizer squirts instead of sprays you are going to -- in my professional and personal opinion we will see increased body counts because of the lack of Narcan program.

So as of Friday close of business the State opioid overdose programs DOH central came down stating the manufacturer and distributor had advised that all atomizers that have not been distributed, send them in for return, but they have not really stated to stop using them or not. The manufacturer clearly for liability purposes is saying it's not atomizing so, therefore, they really should not be used. But DOH is in a quandary, do we shutdown Narcan administration across the entire state because the atomizer may or may not atomize instead of squirt material? So that's where they are now.

DR. MURPHY: I thought it was just the one brand?

MR. MURPHY: It's the one brand and those numbers. However, most of the Narcan

that was supplied through the AIDS Institute came with that numbering, the lot numbers in the 300 series of the nasal atomizer, including our internal atomizer from McKesson so my guess would be there is a lot of those out there.

MR. HUGHES: I know the last two batches we have are different lot numbers. We are at 151 lot and the lot they are looking at is 160 on up. So I think anything that we have distributed should be okay because it's at the 151 lot number. And I checked all the stock we have currently and we are valid with the 151.

MR. MURPHY: So that's spinning around and again --

DR. MURPHY: Well, it's an issue. Is it L-A-D-D? What is the company?

MR. MURPHY: L-A-A-D --

DR. MURPHY: Yeah, right --

MR. HUGHES: From 300 --

MR. MURPHY: -- 300 series with 1600 lot numbers.

DR. PAPISH: They have a BDM --

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DR. MURPHY: Yeah, that's what is going -- but if it doesn't atomize and pours all this liquid down the nose you are going to be bagging.

Okay. Thank you, Mr. Murphy.

Next, service upgrades. There are none for this meeting today.

Evaluation Subcommittee report? We haven't had any cases, but Dr. Arshad is not here -- but we haven't had any.

Helicopter Committee report, Dr. Stuhlmiller?

DR. STUHLMILLER: I reported today, on August 22, 2016 I accepted the position as Chief Medical Officer of Air Methods and so this will be my last meeting here. I will no longer be the Medical Director for the Life Med of New York program, the Harris and Wallkill bases. And I'm happy to announce Dr. Jonathan Berkowitz will be the Medical Director for those two bases, which serve the Hudson Valley Region.

So I have thoroughly enjoyed the last 11 years coming here and I learned a lot from

this group in terms of professionalism and collaboration and made some friends along the way that I'll miss as I'll now be working half time in Denver where Air Methods is based and halftime as an emergency physician closer in New Jersey where I live.

As a last motion I would like to nominate Dr. Berkowitz to become the Chair of the Helicopter Committee for the Hudson Valley and Westchester regions.

DR. MURPHY: All those in favor? Unanimous.

DR. BERKOWITZ: Thank you guys, very much. I look forward to taking on the role and if I have any questions I have Dave's phone number.

DR. MURPHY: Are you still -- does that impact your Westchester -- you know -- job and stuff?

DR. BERKOWITZ: Not really, they are fairly mutually exclusive. It's not --

DR. MURPHY: Okay, great.

DR. BERKOWITZ: It's manageable.

DR. MURPHY: I think on behalf of the

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committee and just to thank you, David, you know, when we started this so long ago -- I can't believe it's 11 years -- there was a lot of crevasse between air rescue and ground. And I think we have done great things here with you to make wonderful policies, protocols that work, a delivery system and the entire setup has been just streamlined and made wonderful so we cover the regions and outposts that have no care -- or very little care -- and, you know, service our patients well. And I thank you for all the time you put in because it made a big difference. I remember when I first started here, so thank you so much.

DR. STUHLMILLER: Thank you.

DR. BERKOWITZ: I would like to bring something up --

DR. MURPHY: Look, he just started --

DR. BERKOWITZ: I want to get to work, you know.

One thing I would like to do is the issue of use of hospital helipads for medivac has come up. I would like to address that

issue. You know, when I've gone over with various legal consultants they said, you know, it's fine to use a hospital helipad for medivac as long as it's part of EMS protocol and nowhere in any kind of our existing set of protocols does it explicitly say that.

I would like to just suggest some language we could agree on and if we say it's part of our protocol any legally-minded person can say it's part of the protocol as opposed to ad hoc or historical processes.

Any questions about that?

DR. MURPHY: No. I think that would be great because, you know, it's ours and it's going to be everybody's issue and people I think have kind of not put it in writing or had something concrete. Devise the language, bring it forward --

DR. BERKOWITZ: I have language.

DR. MURPHY: So we have a your -- Dr. Arshad walked in. We can vote today. Go ahead.

DR. BERKOWITZ: So it's a little lengthy because I'm trying to make it -- hospitals in

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the region may elect to allow their helipads to be used for medical evacuation for patients from the scene where the ground ambulance personnel transfers care to the helicopter personnel without taking the patient into the hospital emergency department. When hospitals elect to do so as part of the regional air medical utilization plan, the hospital with the helipad does not have an EMTALA obligation to the patient unless EMS, the patient, or the patient's legal representative on behalf of the patient, specifically requests a violation by the hospital with the helipad. Those hospitals that allow use of their helipad for medical evacuation were released in advisory form information regarding how EMS can utilize their helipad.

So a lot of this was just taken literally from EMTALA, saying it's a protocol, we allow it. And then on the back end I expect the hospitals that allow this would provide the REMSCO, say, this is how we do and release advisory that would go to the

air medical providers, on ground providers, so everyone knows we are allowing it and this is the process and I think -- I believe it satisfies all the legal requirements.

DR. MURPHY: It makes it cleaner.

DR. BERKOWITZ: Yes.

DR. MURPHY: Do you want to make a motion that we accept that?

DR. BERKOWITZ: Any questions?

DR. ARSHAD: A quick -- I enjoyed the language and craftsmanship. Is there a precedent to EMTALA for the use of helicopter --

DR. BERKOWITZ: There are two in the EMTALA law specifically allowing use --

DR. MURPHY: That's what he took the --

DR. BERKOWITZ: It's just saying -- we are just putting the language in there, if you read the State protocols they say the same thing. They also put in -- they say the same thing, as long as it's part of EMS protocols. We are saying this is part of your protocols, this is part of the operations, this what we do.

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MR. BENENATI: This ties nicely with a piece Dr. Papish will discuss later as well so I think this is really appropriate to do.

DR. MURPHY: I think everyone will want to do the same thing. What we will do is put it forward from the Hudson Valley Region, but I'll bring it, or just send it to Mike and they can talk about it from a collaborative portion. It is an administrative kind of thing so we'll put it into each one of our individual things, but we should share it with everybody so we are all on the same page and we all come with the same organization and word.

DR. STUHLMILLER: It was 2009 that interpretive guidelines from EMTALA came out with specific language allowing this practice, this is just a shorter version of what is in the interpretive guidelines.

MR. HUGHES: Quick question, do we need an agreement with each hospital that we can use the helipad on the EMS side?

DR. BERKOWITZ: The way I laid it out and what I envision is, this says it's

allowable and when they choose to do so, it's part of EMS protocol. The hospital will have to then come and say, this is -- it's an advisory -- probably use you to release the advisory -- saying you can use our pad, when you choose to use our pad this is what we expect to happen. And then that can be sent to the dispatchers for the helicopter, that can be sent to the ground services, so that it's agreed, so people know and it's common knowledge and it's transparent.

DR. MURPHY: I think the transparency is what is key --

DR. PAPISH: Operational protocol, security has to be notified to secure the zone --

MR. HUGHES: My concern is it will take a long time to get every hospital to agree to the terms.

DR. BERKOWITZ: I think it will be easier for the hospitals to do with something in writing. We are paving the way to allow the hospital to have something in writing. I think that one of the things that are

happening in all hospitals is that everything is getting -- policies are getting firmer in every hospital, where we want everything to be in writing. We want as little -- as minimal things, you know, oral tradition so to speak. The way we are going to move it to written tradition is by having us agree it's allowable. Then we can take this, you know, on hospital side, can go to the hospitals and say look, it's in operations that you can do this, there is no reason not to do this. But it's going to be very hard for potentially some of us to take this and have it actually -- truly press it without it being in EMS protocols, which is kind of what is in the interpretive guidelines Dave was talking about.

DR. MURPHY: I think we have to start -- it is what Dr. Berkowitz is saying, we have to be the ones that say this is what we recognize, this is the standard of care, this is what we think should happen, that's where it should emanate from, that's very good, I think, and then we can bring it all forward.

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I think it's not that we have to wait on any institution, every institution that has a helipad has protocol how it gets done, how do we accept a helicopter, how does the process go, how do we summon a helicopter. This would be offshoot of that, but have to include this issue in there. We don't have to be the person to make sure they do it, that's on them if they want to legally protect themselves. We are giving them the avenue to go in the proper way.

DR. BERKOWITZ: Right. Ultimately we want it written so in 10 years --

DR. MURPHY: And we protect everybody in the field and the ER docs --

DR. BERKOWITZ: Absolutely, it doesn't turn into --

DR. MURPHY: He said, she said.

DR. BERKOWITZ: -- and kind of everyone understands what is going on.

DR. MURPHY: Perfect. Look at that, you are not even a minute in the position and you are already on board.

DR. ARSHAD: Can I ask another question?

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What is the second EMTALA exemption?

DR. BERKOWITZ: First one is use of EMTALA for -- use -- I'm not sure which is first and second. But the first is for use for medical evacuation and the exception is as long as it follows EMS protocols.

The second exception is used for interfacility transfer and that was a different criteria. That criteria for that are that the medical screening examination has been performed, the patient has a maximum -- treated and stabilized. So it's entirely different exception --

DR. MURPHY: And it's accepted at the other facility and goes on --

DR. BERKOWITZ: It's an entirely different process. This really is meant to capture the first part because the second part we can't guarantee that any of that happens.

DR. MURPHY: Dr. Arshad, good morning. I skipped right over your evaluation subcommittee report, but we didn't have any issues.

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MR. BENENATI: Just a point of order, we have a motion that hasn't been approved.

DR. ARSHAD: Nor seconded. I second Dr. Berkowitz's motion.

DR. MURPHY: All those in favor?

So unanimous again.

So I just wanted to, you know -- and also we talked about the collaboratives -- and I wanted your input.

DR. ARSHAD: I sincerely apologize for being late. I worked 7:00 P to 7:00 A, my relief lives in New Jersey and forgot that he was on, so my 12 turned into a 14 and a half --

DR. MURPHY: You look pretty good --

DR. ARSHAD: I'm so excited to see you guys --

(Everyone is speaking at once.)

DR. ARSHAD: Just an update on the collaborative protocols. There is a whole host and I saw that the rollout drafts document was distributed to everyone. This is created by Chris Fullagar, out of Syracuse, New York, who is a Medical Director

and HEMS physician. We are working to bring a dynamic educational process to this newest iteration or innovation to the first education of the collaborative protocols. So we have two pod casts recorded, which I'm currently mastering and producing, on some pertinent updates to the State Collaborative Protocols. And the idea is to talk about some of the nuance, the insight, and the reason that we are moving toward some of the newer evidence based protocols and to align the regions within the State so these are very exciting. They came out very well, high performance CPR, cardiac arrest, some of the basic stuff and go through the overall manuscript. As we know, Dr. Murphy created an excellent end of life presentation.

And then we also secured $25,000.00 in grant funding from Laerdal to produce really high quality simulations, which we are going to record on November 21st, 22nd and 23rd in Wappingers Falls. So we have a tight core team, everyone is invited to participate. And we have created Polos (phonetic) for the

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folks that are going to be participating in the simulation so we are not calling out any particular agency, they are neutral New York State medic protocols.

Chris and myself will do the introduction and we will have a host of ALS skills and BLS skills, which we want to get out to the populous and those include topics ranging from high performance CPR to advanced laryngoscopy maneuvers, Bougie assisted intubations. And then we are also going to do something on emergent deliveries or prehospital obstetric emergencies using the simulator and run through several modules there. We are planning on anywhere from, you know, 16 hours of shooting video and then they are dedicating a significant amount of resources to produce that, cut that, package it in a beautiful format and, of course, we will release for free for all the providers and the State. I suspect it will spread a little beyond the State.

DR. MURPHY: Very good. Thanks to Laerdal, thanks to you and Chris. It's been

a lot of work. Protocol Committee here in the Hudson Valley have done amazing work. Okay, thanks.

DR. ARSHAD: And just to chime in -- no updates from the Evaluation Subcommittee.

DR. MURPHY: Okay, RTAC? Dr. Berkowitz, anything?

DR. BERKOWITZ: I don't think -- the only thing that was there was Dr. Marini has stepped down. I don't think we arrived at knowledge of who is going to actually be leading the next RTAC. So there was discussion and ultimately the discussion was to go to State and to see what they are envisioning for governing process. Because the -- we are still waiting for new regulation and the old were slightly antiquated, so that is up in the air.

There was a selection of other topics. I'm trying to see if there was anything else. We discussed telemedicine a little bit, but I don't think there is much happening with that yet. Is there anything else you remember?

MR. HUGHES: Pediatric age --

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DR. BERKOWITZ: Oh, yeah.

DR. STUHLMILLER: We tried to put that out of our minds, it was five minute discussion that --

DR. BERKOWITZ: That took a lot longer and I don't think we reached a resolution. There is a variety of ages being used in the region from the -- from 14 above being adult to, you know, above 18 being an adult. And the problem, I think, that from the EMS perspective is that it's really hard in the field if every hospital uses a different age to know what is going to happen. If you are a little bit further from the pediatric hospital, but the kid is going to have to be admitted and you just take them to another hospital and they are going to get transferred that is probably not ideal in terms of resource utilization. We didn't reach a resolution on this issue. I think it's hard -- some of the centers said it's hard because the trauma surgeons might be willing to take care of patients under 18 that were to fall into ACS level -- I think

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ACS is 16. The trauma surgeon might be willing, but the specialist won't. And so it is really a complicated thing. I don't think we are going to get resolution in the near future, but I think it's important that we continue to raise it with the trauma colleagues and hospitals themselves because it's not really fair, I think, to the patients if they are kind of getting shipped around just based on age.

DR. MURPHY: I think that's a huge point. I'm going to turnover the conversation --

DR. PAPISH: I was going to ask before I bring this up, what is our protocol? I mean, is it sort of, I know it when I see it kind of? Is there a definitive cut off, or are we using an anatomic and physiological --

DR. MURPHY: It's a thing -- David, you can look up the exact verbiage -- we pushed back and forth the ages and everybody uses different ages and that's the problem. So what Dr. Dailey very -- he thought the best way and the best way for all of us to be on

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the same page is for the criteria to be anatomic and physiologic. Because it's very difficult --

DR. PAPISH: It's difficult because if you put out protocol for how to manage somebody that is acutely traumatically injured and you have to sit and vacillate whether this truly counts as pediatric or adult -- so I'm going to talk briefly about this REMAC advisory we were going to send out.

MR. BENENATI: Pediatric patients are defined by the AHA, quote, children without secondary signs of puberty, end of quote, is what the collaboratives use.

DR. BERKOWITZ: Yeah, so I think that that is -- I don't think -- that's kind of a hard sell in some cases. In fact, I mean with -- that with the increases of precocious puberty that is happening, regardless there --

DR. PAPISH: There are nine year olds with --

MR. BENENATI: With beards --

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DR. BERKOWITZ: Exactly, there are 10, 11, 12 year olds who are pubertal. So are we saying those are going to be adults? It's the hospital's function raising a number, certainly the region --

DR. MURPHY: Yeah. I think the hospitals all like to put a number, an age. We were staying out of it by just putting anatomical because we are trying to make this not so prohibitive. Go ahead?

DR. PAPISH: It almost sounds like that's an issue we should try to make better. I don't know if there is a way to make it better because whatever you choose it will be arbitrary. If you say 14, you could have a 14 that is clearly a pediatric patient and a 14 that is clearly much more adult.

That being said, what I wanted to put out was a REMAC advisory -- as we all know, I think it was a few REMAC meetings ago we discussed sort of -- there has sort of been a push from the State to recognize pediatric trauma patients, once you have determined that a pediatric trauma patient should be

transferred to a pediatric trauma center if they are significantly injured. I mean, the edict was all pediatric trauma patients should ideally be transported to pediatric trauma center, but that's somewhat difficult. And we had a big discussion -- for those of you that were here a couple REMAC meetings -- about the implications of that, in a sense that, ideally that be would perfect and ideal trauma care. However, it's a significant endeavor to likely put a child into a helicopter that has mechanistic criteria, but doesn't look that bad and subject that family to a $25,000.00 -- not -- I don't know, some expensive bill potentially -- if they don't need it. At the same time we recognize there is a big problem in the State. There is data to show we have times exceeding six to seven hours for pediatric trauma patients brought to local facilities and then secondarily transferred and that secondary transfer is, you know, definitely not the answer we ideally would want.

Looking at the issue. What I did, I

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just made a REMAC advisory -- do you guys have a copy of this? No? If you don't want me to read it --

MR. BENENATI: She is ready to go --

DR. PAPISH: Thanks. I'm a little wordy --

DR. BERKOWITZ: Worse than me?

DR. PAPISH: Yeah. You can read it at your leisure, but this is an advisory, it's still sort of in formulation, but almost done. I noticed I have a typo on line three -- so it needs some work.

The idea being pediatric patients traumatically injured that met the anatomical or physiologic criteria, based on CDC definition for major trauma, those should be brought to pediatric trauma center. If you look at those criteria, the anatomic and physiologic, those are all significantly injured children. The mechanistic criteria is I think where the area gets a little softer. In the sense that you can have children that have a high fall, but are essential okay and look okay. If that was

the only criteria mandating them to be sent to trauma center, perhaps those patients could be sent locally if indeed it was really very far. But indeed I think every patient that meets the anatomic and physiological criteria that merits a patient with really potential significant injuries and the idea would be that those patients go to pediatric trauma center.

So this is just a REMAC advisory, that we wrote that reminds people of that and has a couple other propositions.

One, they should be transported to pediatric trauma center primarily unless they are too unstable. Obviously patients that are in respiratory, cardiac arrest should be brought to the closest capable place that can initially take care of them. And if the transfer seems they would imminently decompensate by going for long transfer or if they are over 45 miles out, those patients, obviously, we should be thinking about the helicopter for the critically ill patients that are more than significant distance,

within a more than 30 minute ground transport time to pediatric trauma center. Just reminding people that early notification, putting that helicopter on standby has a much greater likelihood of allowing them to be on the ground when you are ready to transport as opposed to waiting for the helicopter. We don't want people to be waiting for the helicopter at the scene. And this is what was sort of brought up, is the issue of having a patient secondarily transported by the helicopter at a local hospital that has a helipad, it's not an EMTALA violation to head towards the hospital that you would under ideal situations not to go into if you want to bring those patients to a pediatric trauma center, but at least this gives the ambulance service an out if the helicopter is not there at the time that they are ready to roll, to go somewhere that they could go if they had to with the plans of meeting the helicopter and having the patient transported to pediatric trauma center at the same time you are heading towards a situation or an area

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where you could receive care, if necessary, and then get secondarily transported in the event that the patient decompensated.

So read through the REMAC advisory -- if anybody has any comments? But I think that it's really not any real change in protocol as much as a reminder and just a request to consider using the local hospital helipad to facilitate transfer for seriously injured children.

DR. MURPHY: And the thing we brought up last time is launching early. If you do recognize there is a patient of desperate need and needs to be level one trauma center you don't wait and do seven CAT scans and wait six hours and you get them there quicker and discuss it with your trauma center, i.e., Westchester. And, you know, make the decision early and, you know, get them there at a proper time so there isn't that secondary delay. I think that's huge. People need to realize you don't have to be shy or scared that you don't have every CAT scan, you don't have every single test to

mankind and just determine that the patient needs to be there and get them there. I think that's huge.

DR. PAPISH: We started a policy at our facility with patients that meet the definition that they should end up in pediatric trauma center. When we get the notification from EMS we put the helicopter on standby automatically now. And we have had good success and gotten those patients that are critically ill and they've come in through ER, we've done a resuscitation and pop them back and the helicopter is there. And so it's facilitated getting them in and out very quickly.

DR. STUHLMILLER: I think that's something all hospitals could do.

And I have to say that the reference to the cost of helicopter transport shouldn't really have any bearing on what is -- doing what is right for the patient as the cost of health care for a traumatically injured patient is so much significantly higher than the cost of transport. I don't think that

should be a deterrent from using the aircraft when it's appropriate for the patient --

DR. PAPISH: The only reason that was mentioned is that was the primary -- when we were discussing this several meetings ago the big objection most people had been using, the helicopter was subjecting patients to such an additional cost. I agree with -- you know, I don't know whether if --

DR. BERKOWITZ: The cost of the ICU stay is --

DR. PAPISH: One day in the ICU --

DR. STUHLMILLER: The cost of stopping interhospital to have six or seven CAT scans and two or three consultations prior to transfer is probably similar.

However, that's often spoken about as a concern. And although it's a concern, if you want to start to talking about costs of health care, that's a health care policy cost debate, rather than a utilization.

DR. PAPISH: We can change the verbiage easily. Perceived expenses, it's the main reason -- I think one of the main reasons

people are hesitant to utilize the helicopter more frequently. They are afraid of somebody getting transported safer mechanistic criteria not being that injured and getting up and they turnaround and saying --

(The speaker cannot be heard.)

DR. PAPISH: -- I'm sure that's happened.

DR. STUHLMILLER: Sure, it happens. I would approach that as an appropriate utilization for medical reasons, not fear of using the helicopter because of what it might cost when it actually was needed. So I would turn the conversation a little.

DR. PAPISH: We can change the verbiage --

MR. BENENATI: Certainly that's an appropriate consideration. We, being EMS folks, concentrate on that piece of it and don't look at the whole picture. I think when you do put it in perspective they have valid points about using a tertiary or additional facility.

The other important thing to understand

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is when this process started the folks in Dutchess, working with Westchester, already started a Power Point presentation. And this is a piece of that, but we would need to educate all of the EMS providers in the region. And it can certainly be a part of that presentation as it's rolled out as we move forward.

DR. PAPISH: Good idea. So this didn't need any kind of voting, we were just going to modify and send it out.

DR. MURPHY: Yes. I think just that we have the conversation -- again, I think it's still an ongoing conversation, but I think that we have to not fear utilizing air transport and just treat people and get them to the destination they need to be. I think that's the most important part of the whole process.

So speaking of trauma -- nice segue.

Department of Health sent us a cc'ed us a letter notifying us that Mid Hudson Regional Hospital will be granted an extension --

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DR. PAPISH: Will not -- not granted an extension.

DR. MURPHY: Oh, they are not?

DR. PAPISH: They asked and they said no.

DR. BERKOWITZ: You look so surprised.

DR. PAPISH: I'm not surprised --

DR. MURPHY: I miss-worded (sic) it. They asked for extension, but the Department of Health said no. And that the Commissioner, you know, with the STAC have said that New York State wants every single one of the trauma centers to get ACS certification, American College of Surgeons. So that's why -- they are saying based on this example they are denying the request. And that they want during this time period the department to continue to recognize and move towards becoming a regional or designated area trauma center within REMAC. And it was from Lee.

DR. PAPISH: I thought it was interesting though, it did say something I didn't know, that even if they -- if a trauma

center didn't meet the criteria based on their survey, they still have another year before they actually lose their trauma certification as long as they undergo an intensive focus review within a year.

DR. ARSHAD: So the practical implication is it's still a trauma center.

DR. PAPISH: The truth is they were asking -- I happen to be in the know -- they were asking for extension because they wanted to consolidate a couple aspects of the trauma program to make it irrefutable they wouldn't have any issues. And they were on the fence as to whether they needed the time and they figured they would ask and if they got it, they got. I think they are gung ho ahead and will be fine. But the pertinent part of the letter is if they didn't pass their survey you still have another year -- which I didn't know -- or at least they granted them another year to rectify whatever the issues were.

DR. MURPHY: Quality improvement, Jeff?

MR. CRUTCHER: The movement towards Nemesis 3 in New York continues. At this

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point in time all EPCR vendors should have a fresh copy of the New York State data dictionary reflecting all the changes. We are in the process of migrating some of the smaller agencies to Nemesis 3 Bridge so we can workout any problems. It's much easier to do when you are looking at 10 or 12 documents being uploaded than thousands. So work on that progresses.

DR. MURPHY: Great and thank you.

Protocol Committee, Mike? I don't have -- if you have anything else?

MR. BENENATI: We have a meeting on Thursday. Most of the stuff has been reported, we have another meeting on Thursday.

DR. MURPHY: For anyone in the room if you want to become involved in the Protocol Committee it's definitely feasible, just contact Mike and put your name forward.

Under new business, so a few things have come forward that I need to notify you about.

First is Port Jervis Volunteer Ambulance Corp has been operating -- I guess I don't

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want to read that -- basically they decided to liquidate all ALS equipment and downgrade to BLS as of November 5th at 7:00 a.m. The Corp will remain staffed with full BLS crew and ready to respond 24/7, but the liquidation of the ALS is because they have had a hard time with basically filling their shifts, keeping it 24/7, and trying to operate in a financially feasible method. So as of November 5th they are no longer providing ALS services from Port Jervis volunteer Ambulance.

Next, under new business, we had a proposal set forward by Hatzolah EMS of Rockland County. And they are requesting for us to look at the proposal of adding AEMTs to our current system and to follow the standards for AEMT certification.

And -- did he leave?

MR. HUGHES: No B.J. is in the corner --

DR. MURPHY: Sorry, you guys moved on me. What is the thing with the chairs? Go ahead.

MR. LEIDNER: Basically we would like to

add the AEMT program in conjunction with the full paramedic program we have. Basically it gives -- our community is growing, the area that we cover is expanding and this way our patients can get some basic ALS coverage until the paramedics get there. We still are going to continue our full paramedic program. We have 25 paramedics that are volunteers and it gives the chance for our EMT to move up the ladder to become paramedics in increments and go for AEMT, and the ones that want to move up to CC and paramedic, they all are volunteers and full-time jobs. New York State allows the AEMT and the region has protocols for it so I think it's pretty much -- it's there.

DR. MURPHY: Yeah, we have -- just a little background. We just never had the level of certification in this area, just background. I don't know if anybody wants to talk in the room that has -- Mr. Murphy start.

MR. MURPHY: Actually, I think what Hatzolah is asking for is a revitalization of

a program they had in place for many years. They actually had EMT-I, it's AEMTs many years ago. I actually taught their original programs. And they had a huge influence of paramedics over the course of the years and kind of let the AEMT program fall to the wayside. Now what they are seeing in the community is a huge growth in demand, a not a lack of paramedics, but because of the large area it's difficulties in responding sometimes in a timely fashion. Not that they wouldn't respond, but there might be a paramedic responding from the northern area of their territory down to the southern area. So what they are looking to do -- if I'm correct, B.J. -- is reinstitute a program they had many years ago, the AEMT level. And in those days it was the CC, now it's what we call the AEMT.

So I would speak in favor of that, knowing the organization very well and knowing the members and also knowing the logistics. They are not looking to replace the paramedics with AEMT, they are looking to

supplement the paramedics. So if they have ALS as first responder the paramedic would always be en route to that location. They can be called off with assessment, but they would always be responding with the AEMT. And when they are on the scene it would be the paramedic, plus the AEMT as additional set of hands. They do a fair amount of transports interfacility and long distances so would have additional set of ALS hands in the ambulance during transport. Again, this is not something new they are asking for, this is revitalization or resurgence of something they had in the past.

DR. MURPHY: David?

MR. VIOLANTE: I would like to echo Mike's comments. I think it would help to provide another layer of care, specialized care to an individual in an area such as theirs with greater population and need. Arlington, we had EMT-Is back in the day -- I can't believe I can say that -- but we did have them. It was successful for us. It is revitalization of that kind of thing. We had

them here in the region. It's possible as long as they continue to have paramedics and continue that process -- which I believe they will -- I think it's a good thing for them particularly to be able to do this as well.

DR. MURPHY: I think that's the main point. You are not looking to replace, you are looking to augment and to just kind of give a steppingstone for the younger guys to move up and continue their education and get to that point and still provider a higher level of care.

I think that Hatzolah has to be recognized as a very well-organized. And just during my time here -- which is even longer than 11 years, David -- I've seen incredibly great strides in performance with Hatzolah. And this past year Orange Regional gave you guys an award for it. So I think that's an issue that, you know, goes without saying. I think some of the reason people had problems in the past is they were worried about volunteer agencies, you know, gaining access to higher level of care and then

folding. And it just happens to fall on the day I announce -- sorry, Port Jervis -- but I think we have no risk of that with Hatzolah and I don't see any problem with it. I had to bring it to the committee though because we need to talk about it because it is our local region.

DR. MAO: Motion to approve.

DR. BERKOWITZ: Second.

DR. MURPHY: Any other discussion?

DR. PAPISH: I don't want to belabor the point, but does anybody see a downside?

DR. ARSHAD: What are the practical implications.

DR. MURPHY: It's only -- like we said we tried to -- there was a little while there -- you guys can step in at any time if you think I'm wrong. There as a little time there where people were trying to use these intermediate levels instead of delivering a paramedic to the scene when we felt a paramedic needed to be there. Now, it happened during the time we were stretched to the ninth of paramedics and we just didn't

have enough to go around. And there was times when we had the I so they could intubate and do these things and advance their level of care delivery at the scene. We didn't like to see that being supplanted and not having people still get to the level of paramedic and have that higher level of care and that was the fear for the longest time.

But I think that's really not a point, I think Hatzolah has proven themselves and I think it's recognized. There is many places in our collaboratives up in Jeremy's area, up in the north state, that AEMTs are vital to their organization and their structure.

So with that being said any other --

MR. HUGHES: One of the things in our medical control plan, it's what we call the two-tiered --

DR. MURPHY: Response --

MR. HUGHES: -- response, where the AEMT will go to the scene and then the paramedic also has to be dispatched at the same time to go to the scene so I think that is part of

the reason it was covered in the medical control plan also, so that's still in effect.

MR. KNOBLOCH: We from Kiryas Joel has this AEMT and EMT-I in place as well and it was in conjunction with the paramedic, who is never by itself. And I agree with Mike and everybody else that it's good steppingstone to go from EMT. It gives you a little bit of the skill beforehand so you know what you are dealing with and move up to paramedic level.

DR. MURPHY: I think it's a sense of comfort they can do it because I think that's one of the biggest things, people say, am I capable of handling the scene? And it's a nice steppingstone of maturation.

Any other comment?

Since I have a motion and second on the floor I'll ask for a vote.

All those in favor of allowing the AEMT program to come back up in Hatzolah EMS, all those --

DR. ARSHAD: Is it Hatzolah EMS specifically, or our region --

DR. MURPHY: It will be our region.

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They will the first ones.

Unanimous again, thank you.

Okay, SEMAC report. I can't think of anything from SEMAC we haven't covered. I can't think of anything.

Mike, can you think of anything?

DR. ARSHAD: Check and eject data pilot was fantastic we saw --

DR. MURPHY: Yeah. They gave the secondary report of that, it's still going on. And what it is is the check and inject, the process of making prefilled syringes for epinephrine because the Epi-pens became so expensive and exorbitant for each agency to be able to afford. Out of the REMO region they devised a check and inject program where they made their own syringes and they were prefilled such that -- actually not prefilled, but you filled them to a line. So it the syringes is just one line on it so it wouldn't be someone had to titrate or make sure they had the exact mount of epinephrine in there, being .15 and .3. So people weren't running into trouble and it was

extremely well done and they had great success with it. So what was the final thing, they are going to continue as a pilot program?

MR. PARRISH: The vote was to move it forward and I think they are just waiting for the sign off of the Commissioner.

DR. MURPHY: That's what it is, it's on his desk --

MR. HUGHES: Anybody participating will continue to participate and they are actually taking new participants.

DR. ARSHAD: And we are seeing that in the Hudson Valley. For any Medical Director of volunteer BLS agency, local squads, we are encouraging folks to take a leadership position and encourage adoption of the check and inject program especially in the political climate of rising drug costs and critical case of epinephrine we have the opportunity to save lives and hedge costs. So fantastic program, the pilot was very successful. And I think one of the greatest takeaways for me was, there was zero

medication dosing errors. And as medical directors we are fearful of epinephrine and epinephrine dosing error. A robust teaching program, great safety measures and checks in place, zero dosing errors and they QA'ed every case and all were done appropriately.

DR. MURPHY: Just so you know, cost of the kit that comes with two sets of injectors and a trainer was $88.00 or $85.00, something like that --

MR. KNOBLOCH: $85.00.

DR. MURPHY: Which just shows you the difference between marketed Epi-pens now. But it was extremely successful and fortunately moving forward.

It was such a short meeting and that was that. And then they talked a little about two other agencies and changes in some of the verbiage and format.

But -- protocols, but I don't think there was anything else, that was it.

DR. ARSHAD: Brief, yeah.

DR. MURPHY: Next, PAD, Epipen, Albuterol, glucometer and Narcan. I don't

have anything to report.

I do have one notification from the Department of Health. This is a violation of Part 800 against John Huey out of Depew, New York. It's for violation of Part 800. He is assessed a civil penalty of $5,000.00 from the Department of Health. That was the only notification.

And then also included in your packets are the meetings for 2017. We adjusted the one in September, we moved it back one week. Everybody take a look and make sure those dates work for everyone. Those will be the next meetings.

And I would like to open the agenda.

Dave?

MR. VIOLANTE: I would like to give thanks to the regional office staff and ask everyone to participate in something they are doing. Many months ago Dutchess County started an EMS task force in that they did an evaluation in the county and found -- one of the findings was that of all of training going on there is no real coordination of the

training. And so hospitals are doing it and institutions are doing it and training centers, but nobody knew sort of where it was. After the last REMAC meeting we had we spoke to our office staff here about regionalizing the training. And so they are creating -- or have created a new training calendar that will work overall for the region, and then also by county, to provide all of the training informationally to all of our providers so that any organization can submit their training to the regional training calendar and it's available for everyone to see. Providers will also get notifications by Jeff, e-mail, Twitter, Facebook, any kind of social media as to when trainings are occurring, whether they are med control or not, whether they are core content or not, all of that information is in one clearinghouse, in one place. It didn't cost the region a lot of money or time to do it, they really put a foot forward. This was brought up through training and ed and voted on by REMSCO also. I want to thank these

guys for the work they have done and ask everybody here that does training to send it to the region so it gets on the calendar so providers can come to your training.

DR. MURPHY: Thank you.

DR. ARSHAD: Jeff, may I ask what our Twitter handle is?

MR. CRUTCHER: I'll give it to you as soon as I get one, that's the next step in the process.

DR. MURPHY: I didn't even know what the handle was. And then -- yeah? David Grass?

MR. GRASS: How are you? David Grass --

DR. MURPHY: Mobile Life.

MR. GRASS: I made copies that I forwarded off to Bill. Mobile Life Support Services would like to propose a kind of diverse and cutting edge change to the way we provide medical control contact so I'll give you a little background.

We started this program with our quality improvement division several months ago when some of the BLS skills that we wanted to rollout to our staff was necessary. We

identified that because of the diversity and locations of our staff members trying to bring them to a central location was nearly impossible for them to fit into their schedules. So what we developed was with the new advances in the technology and the internet being a little stronger and faster we were able to host a lesson that was audio and video broadcasted live time feed to multiple remote locations. At those locations there would be a supervisory staff member, who would facilitate people signing in signing, signing out. The technology allowed for the CME program to be broadcasted with the presenter live audio feed and live video feed. It allowed for the audience members to not only see the presenter, but also to ask live time questions of the presenter. As we looked at our staff and how we could better serve them, what we found was that this program worked and worked well and it was time for us to bring it to the next level.

That level specifically for us is to be

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able to take a medical control contact or physician contact event that are being done around the area and, unfortunately, only reach a small percentage of the personnel that can attend because of logistics of their schedule and travel time and restrictions thereof, and take this medical control contact time and live feed it to several remote locations. Specifically when I say several, right now we proposed putting two remote locations in place. We would use the same technology, use the same platforms to allow the individuals with a managerial level experience to have people sign in on a medical control sheet, they would participate actively in the medical control presentation, by being able to ask questions, respond to questions, live time feed, and at the end of the day get medical control contact time for that evening in remote locations.

We have proposed the program through a couple of different people, so far everybody has been on board and feels it's a good process. To be honest, listening to

everything discussed today, it dove-tailed behind everything discussed as far as providing the opportunities to the individuals at the end of a session or somewhere during a session that that live sign-in sheet in the remote sites would be scanned and sent back to the host site where the medical control physician could give the ultimate signatures and then dispense contact time from there.

So at the end of the day what we are looking for is the approval of REMAC to bring a program which, you know, really was cutting edge by Arlington several years ago and because of the technology just didn't support it to allow them to do it. We think we have devised a plan and put it together where it can work. We have used it on several occasions, had great outcome. The staff enjoyed it because they didn't have to spend sometimes an hour, hour and fifteen minutes traveling one-way for a one or two hour in-service, spend that time driving back. This program has the ability to take and

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record it. And while we understand that right now we are not giving medical control contact time for prerecorded stuff, we hope that individuals would, A, have the opportunity to be able to review it and still get something out of it, and maybe the day will come where we can review, you know, giving retrospective continuing education contact to medical control when it's being done.

That's my 10 minute speech given in about three and a half minutes. I'm happy to answer any questions.

DR. MURPHY: I think one of the things we have always tried to do here and through the Protocol Committee, tried to work on educational and training program that facilitates medical control contact. Because we really feel that that is a very integral part, we are working with the people in the field and as you all know they come to us in the departments and ask and review cases with us. But like Mr. Grass is saying, that if we could reach more people, if we could provide

more education, if we could really make distance learning such that we facilitate it that they don't have to leave their area, they can stay in that area, they do it remotely, and we put these processes in place that we keep track and make sure it's done legitimately, I think it's a great idea.

I think you just had little light bulbs go off in Dr. Arshad's head over here. I think these are all things that we could do as a region together to facilitate and promote more education and more delivery of that education.

MR. VIOLANTE: Yeah. When we started this at Arlington that Dave was referencing it looked very Apollo 13 at the time. But it did work fairly well for what we were doing, just that the technology didn't completely work-out. I think that's resolved now. In training and education we talked about this a lot. There is a lot of distance education going on in a variety of institutions outside EMS that is working really well. And, you know, a lot of us in EMS are providing some

distance education as well. So I think that this is an obvious next step to providing for to the community of EMS is the providers.

DR. MURPHY: I would like to -- Mike?

MR. BENENATI: The Protocol Committee has also been looking at this for extended period of time working with Mobile Life Support on the pilot project, working with some of the hospitals on that. And the Protocol Committee is ready to move forward as well.

DR. MURPHY: I would like to put a motion on the floor for us to approve this pilot of utilizing remote telemedicine, or teleconferencing -- I don't know what you want to call it.

MR. GRASS: Medical control contact time.

DR. MURPHY: Tele medical control contact time to facilitate these lectures to be given -- broadcast simultaneous to distance and remote sites --

DR. MAO: Just before you put the motion, I think we need to double check with

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the education policy, if the CMC would sign off on it. And does it fulfill state requirements?

MR. VIOLANTE: This is different from state requirements, the regional medical control hours are required for the region. State CME is requirements for someone's certification in a different category. Although people could use this as noncore contact time, this is a totally separate thing.

DR. MURPHY: It fits what we do in the region. We feel people need their CME, but if we designate a portion of it has to be in contact with one of the Hudson Valley medical control physicians. That's what we --

MR. GRASS: Just to address that -- I didn't want to take a take up a lot of your time giving everything in the proposal. The way the program is designed to work, the quality improvement, working with whichever facility is hosting the medical control contact, will pick a subject, they will do a one hour review call audit of whatever that

subject is and then our education department, who is overseen by CICs would develop a one hour CME presentation on that subject, present it to the facility that is going to be hosting two weeks before they do so they can review it, change it, tweak it to anyway they want, and then we'd have all the approval by CIC that has overseen and developing it, we meet all those protocols. Because we all experienced at least one or two times where we have kind of been medical control contact time, but gone over the paramedic or ALS provider's head. So we are trying to steer that into there and meet any of the requirements the State has for CME program where people had the privilege of using for both programs.

DR. BERKOWITZ: I'm pretty sure they are doing this up north as well, in Albany, in the capital region. I'm pretty sure -- correct me if I'm wrong. They might just be doing distance for their regional COM.

MR. BENENATI: One of the things Protocol Committee discussed is the platform,

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so once this gets rolled out how can everybody get into the system relatively easily? That's important to us and we need to look at that as well.

DR. ARSHAD: Great point, Mike. Just to add some color to the presentation, what program are you using for live streaming and what challenges have you encountered thus far?

MR. GRASS: We are using a platform which is called Ring Central. And it's more of an -- if you were to go back and look at it, it's a go to meeting platform, not really a Skype scenario because you can't dial in with an IP address to it. But essentially what we do is we would have an invitation to a remote site where they dial into it and it streams back and forth through this app that flows over the internet. When we looked at different programs this one has been the most reliable. We have been using it just over a year now and have had no major problems.

One of the things we are working on developing is seeing if we can sell the

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Department of Health on distance learning education, taking out that CIC problem from the remote location and going from there -- he is taking my chair out from underneath me. For the first time the gentleman who runs the Department of Health education division is willing to look at our proposal and come up with it. So we really would like to run this one out as a test program. To be honest, if you give us approval we have a date in mind in December and then it takes off every month thereafter. We made contact with two facilities who are more than willing to come on board. Once we get the approval here, don't be surprised if your phone isn't ringing right behind --

(The speaker cannot be heard.)

MR. GRASS: Again, we don't want to reinvent the wheel. What we would like to do is broaden the encroachment area you get of the providers to be able to experience that great CME opportunity by having them.

DR. MURPHY: Any other comments?

DR. ARSHAD: What are the hardware

requirements per site?

MR. GRASS: A reliable laptop, projector, internet capacity, and it would come through there.

One of things that we looked at -- and we wanted to able to answer all the questions we imagined would come up as we round tabled it. We are not prepared today -- or we envision in the beginning of the year to take it out to a site that we don't control. So we imagine if we were to broadcast from this room with a medical control agency that we can take it out to facilities and sites that we control because then we can ensure consistency. While we discussed taking outside agencies and allowing them to dial in, because we don't have the security in that yet or the level of comfort, we are not ready to expand it to that, but envision that would be the next step going down.

DR. ARSHAD: So the go to meeting you are essentially sharing the laptop screen of the presenter?

MR. GRASS: Correct. And it also has

the ability to see each of the remote sites tied in. So whatever they are presenting, a Power Point or live video that was on it, they would share screen their screen and it would present it.

DR. PAPISH: This is with the technology now. We did it with Zoom, we had a little bit of problem with the microphone, which is something that is easily surmountable, but it's a $40.00 deal, it's something that is really easy to do now.

DR. MURPHY: He emphasizes the money --

DR. PAPISH: People don't want to do things because of money, it doesn't cost a lot.

DR. MURPHY: Any comment before the vote?

Okay, all those in favor?

Unanimous again.

Thank you, Mr. Grass.

Open forum. Anything else anyone wants to bring up? Rich Parrish?

MR. PARRISH: Ulster County has their EMS education day at Mohonk on November 26th.

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Dr. Gutman has done a great job of lining up six good CMEs.

DR. MURPHY: November what?

MR. PARRISH: 26th, the Saturday following Thanksgiving.

DR. MURPHY: And it's right at the main --

MR. PARRISH: Mohonk Mountain House at their conference center.

DR. MURPHY: Great. Yes?

MS. FRAZIER: Sharon Frazier. This Saturday, November 12th, we have the EMS connection at Dutchess Community College.

DR. MURPHY: Excellent. Are.

MR. STONICK: We have our 18th annual trauma symposium next Monday, meeting at Sheraton Crossroads, Mahwah, starts at 5:00 o'clock with buffet dinner.

DR. MURPHY: Lot of stuff happening out there, guys, keep going.

Anything else?

Can I have a motion to adjourn?

DR. PAPISH: Motion to adjourn.

DR. McGINLEY: Second.

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DR. MURPHY: All right, thank you everyone 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