----------x

HUDSON VALLEY REGIONAL EMERGENCY

MEDICAL ADVISORY COMMITTEE

----------x

MINUTES OF MEETING, held at the offices of Hudson Valley Regional EMS, 33 Airport Center Drive, New Windsor, New York, on Monday, January 8, 2018, at 9:30 a.m.

Yvette Arnold,

Court Reporter

ROCKLAND & ORANGE REPORTING

2 Congers Road

New City, New York 10956

(845) 634-4200

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

DR. PAMELA MURPHY,
Committee Chair

DR. ARSHAD,
Evaluation Subcommittee

WILLIAM HUGHES, EMT
HVREMSCO Executive Director

JEFFREY CRUTCHER,
QI Coordinator

KAREN DELAUNAY,
Office Manager

CATSKILL REGIONAL MEDICAL CENTER

DR. ANUJ VOHRA,
Physician Representative

GOOD SAMARITAN HOSPITAL

DR. DENNIS MAO,
Director

HUDSON VALLEY HOSPITAL

DR. JAMES CHUNG,
Director

HEALTH ALLIANCE OF THE HUDSON VALLEY

DR. GUTMAN,
Physician Representative

NYACK HOSPITAL

DR. KWON,
Physician Representative

ORANGE REGIONAL MEDICAL CENTER

DR. VOHRA,
Director

PUTNAM HOSPITAL CENTER

DR. BUTTERFASS,
Director

ST. LUKES CORNWALL HOSPITAL

DR. SACHIN SHAH,
Director

VASSAR BROTHERS MEDICAL CENTER

DR. ARSHAD,
Physician Representative

WESTCHESTER REMAC LIAISON

DR. ERIK LARSEN,
Physician Representative

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

RICHARD PARRISH
KIM LIPPES
TIM MURPHY
DAVID GRASS
RICHARD ROBINSON
MICHAEL BENENATI
ISRAEL KNOBLOCH
SHARON FRAZIER

Proceedings

DR. MURPHY: Good morning. Thank you all for coming. I know it could be -- we could be sitting on a nice warm beach somewhere, instead we are in this cold cold wave, but it's going to get warmer. Tomorrow will be 32 degrees, so we are going to be in a heat wave starting this week. One of the things I thought about for the New Year -- and Happy New Year everyone -- was that I know we have this meeting slotted for 9:30 to 12:30. But I just want to make everybody -- and maybe we can assure people -- the meeting will be like an hour, hour and a half. It's rare we go to the three hours and I can't remember the last time since we bring things out of here and into other committees. It makes it so we don't have to do a lot of hands on work here. One of the things to put in your schedules, you could safely say we should be out of here by 11:30 every time so people can make sure they get here and come. And I know 9:30 to 12:30 is very discouraging sometimes to block out our schedule, I appreciate everyone's efforts and everyone's

attendance has been fantastic this year.

That being said, Karen distributed the minutes. They were reviewed.

Can I have a motion or comments for any corrections, deletions, any kind of alterations at all?

DR. ARSHAD: Motion to approve the minutes.

DR. BUTTERFASS: I second.

DR. MURPHY: Thank you. So under old business we need to talk about psychiatric patients and dispositions. That was supposed to be a TAG, no?

MR. HUGHES: I don't know. I thought you were doing a report on that --

DR. MURPHY: No. What happened was I reached out to the State and to Orange County because that's who I have the closest contacts to. So what they are looking at -- and it's actually in the State of the State proposal or report from the Governor -- is they are looking at trying to make certain facilities and places age specific kind of treatment and to look at can we improve the

access to psychiatric care in the State. Because as you know, it's like a nightmare. So as of right now they have made no changes. There is things on the horizon, but nothing has been written in stone to say this is how we are going to make it better. Because as you all know, we are in dire need of more BHU psychiatric beds.

In terms of dispositions and where people are going, I think people are doing better at addressing the patient's needs from a medical perspective before just transferring them to a psychiatric receiving facility.

Anuj, I know you are just taking your coat off -- do you have any issues? We brought this up before about psych patients and dispositions and were patients being medically cleared and sent to the 9-3-3 receiving and such. Any improvement? Any changes? Any comments?

DR. VOHRA: I know in the past one of the problems we had for patients is bypassing other EDs. I think that's gotten a bit

Proceedings

better. I haven't heard as much --

DR. MURPHY: Right. Not as many complaints and not as many individual cases where they used to come across my desk --

DR. VOHRA: Agreed. In terms of our capacity, we are constantly full and challenged about space so when the ED becomes unsafe due to volume we can't always accept every patient that wants to be transferred over because of our capacity and resources. We are doing the best we can.

DR. MURPHY: Any comment from other counties? Any problems, issues, concerns?

DR. LARSEN: Has there been any, you know, progress made on sort of the whole substance abuse thing in terms of referral --

DR. MURPHY: No. I mean they have -- there has been a lot of talk at the State level, but I have to say nothing is formulated. People talk about it. We have to have some kind of place to refer these patients to and into a facility or a place that will work for them, not just a place they are going to go hangout and chill.

Proceedings

DR. LARSEN: Yeah, an expensive urine test.

DR. MURPHY: Yeah. More so a place that really will help them get better.

New Jersey has made -- I don't know if you have been involved or in the conversations or are totally dissolved from New Jersey, but New Jersey has made huge strides at ways -- you can see the commercials on TV, you can see the hotlines. They have made big strides at trying to get people into programs and get them out of -- you know, that, you know, vicious cycle of use. But I haven't seen anything yet from New York, you know, beyond what we have done. Beyond -- the one push that has been really -- getting Narcan has been our biggest push throughout the State. But I haven't seen anything on the other -- the foot coin of it, of rehab and trying to get people better, not much.

Any other comments or concerns?

Okay, BLS protocols update. So we have been meeting all along -- I don't know, Mike,

Proceedings

if you want to jump in? We have been meeting all along, a lot of back and forth e-mails. And we have had -- split up all the BLS protocols among many practitioners to look at and review and bringing back to the State, so the State is compiling them. We should be almost done, right? I mean, I think we are bringing forth tomorrow the last of the first drafts of all of them for the committee to look at and go to the State.

As you know, tomorrow Lee retires -- Lee Burns retires -- that's who we have been kind of driving this all with. So I'm not sure what is happening, are they replacing Lee?

MR. ROBINSON: Yes. The acting director currently is Andy Johnson --

DR. MURPHY: He is going to take that hat on for right now?

MR. ROBINSON: He was the highest grade in the office so he won.

DR. MURPHY: Okay, he got the short straw.

MR. ROBINSON: I guess.

DR. MURPHY: We should be able to move

them along tomorrow so we will see what happens, but pretty much we went over and upgraded all of the BLS materials to include the newest modalities that have been brought forth for their curriculum and -- anything else?

MR. BENENATI: No. Tomorrow it will be a good discussion to see where we are at, but they are not looking for a motion to adopt them tomorrow because they were lots of comments from EMSC and from the STAC. But other than that, it's just moving forward, maybe at next meeting.

DR. MURPHY: Yeah, they will go through standards in the morning and discuss some of the stuff and some of the comments that have been made. So that's on the horizon, it's well into it. People were pretty hard on all these things, it's been a great effort from many many people.

Service upgrades. I have none on my stuff. Do you have anything?

MR. HUGHES: No.

DR. MURPHY: No. Evaluation

subcommittee?

DR. ARSHAD: We do have one case to review and it was referred to Jeff by a Dr. Stutt, who was formerly -- sat on the REMAC for several years.

Regarding a 66 year old male, date of service was in October, who presented with respiratory distress and ALS was dispatched to the scene. So I'm just going to do some reading.

There were some communication issues, which we will be discussing, as well as some medical management issues.

The summary as described by Jeff is, the patient had recently undergone successful surgery for lung cancer and was recuperating at home with wife and family when he was found to be in respiratory distress. The initial vital signs are reported including a peripheral heart rate of 150 and oxygen saturation of 98 percent with initial assessment of the patient in moderate respiratory distress.

One of the concerns the family had is

that no attempt was made at an oxygen saturation within the home due to -- or rather there were challenges in obtaining the oxygen saturation at home because the patient was diaphoretic and clammy. And in review of the PCR the initial saturation is reported at 92 percent.

There was also a concern in regards to the transfer of the patient onto the gurney. They said EMS did not help facilitate the transfer of the patient onto the gurney. In the PCR the documentation reads that, family and PD helped with the facilitation of the transfer of patient onto the gurney.

Now, one of the main issues that came up was the code status of the patient. So a lung cancer patient that had undergone a recent lobectomy at Vassar, apparently the family in the review of the Health Quest note had conversations regarding the potential code status, or changing the code status of the patient. However, the patient remained a full code and they reemphasized that the lobectomy had been successful in removing the

Proceedings

area of cancer.

Now, the paramedic in the back of the ambulance who was teching thought that the code status was, in fact, do not resuscitate. The patient's wife was riding in the front of the ambulance and was the health care proxy. There were challenges in obtaining a successful IV, which are corroborated in the PCR. During the transport the patient degenerated into a pulseless electrical activity, or a PEA, and became minimally responsive. BVM was initiated by the paramedic and pacer pads were placed. There was communication from the back of the ambulance cabin with the health care proxy and the communication was unclear it seems like, though the wife indicated that the patient should be resuscitated fully.

Ultimately there were challenges in electrically pacing the patient. Though in the PCR it says pacing electrically was considered.

The care was transferred over to Vassar Brothers where the initial management was

Proceedings

relatively conservative until the patient's daughter, who is an ICU nurse, who works for the Health Care Alliance of Hudson Valley, phoned into the institution and said, no, in fact, the patient should be full code. And then all measures were taken.

Now, in regards to the review, the PCR is written with incredible eloquence. When we discussed with Matt, one of the supervisors with the agency, there was some communication with the paramedic who was admittedly flustered. Who, nevertheless, emphasized her impression was that the patient was, in fact, do not resuscitate.

There was some education done regarding bradycardic rhythm, pulseless electrical activity and management of patients especially in decompensated shock, which was received constructively.

So that is the case. I just wanted to see if there were any questions which the committee might have.

Ultimately, we determined that there were some communication issues, the paramedic

was reeducated and accepted that constructive criticism well.

Some of my thoughts are, code status is certainly something that is challenging and when there are questions or it's dubious what the patient's code status is, it's always appropriate to be more conservative in the management and assume that the patient should be resuscitated as a full code.

Additionally, some things that I've seen as an EMS medical director are, there are a couple of things which remain challenging because they are described as HALO encounters -- that's H-A-L-O -- high acuity, low occurrence. And managing symptomatic bradycardia is, in fact, one of those challenges and issues. And, in fact, is something that is not only a limitation at the paramedic scope of practice, but, in fact, as emergency physicians we do not see that often as well. And it's something we have to be diligent in regards to maintaining our skill set and proficiency in that regard, especially when we get into transvenous

pacing and the intricacies and nuance of both placement of the electrical wires and then management of our electrical pacing device.

So some of our summary statements are in regards to symptomatic bradycardia, we should emphasize these are rare occurrences, but nevertheless the patient is often critically ill, so we should engage in in situ simulation to not only practice the skill set of both chemical and electrical pacing, but also in bed scenarios in a simulation so we can upgrade our paramedics' medical decision making. Especially for younger paramedics who made not be as used to these scenarios that may occur one, two, three, four times in an entire career it's important in regards to critical airway interventions, symptomatic bradycardia, something that comes up over and over again, the management, pacer pad placement, as well as something that is also really common is patients in moderate respiratory distress are often given Albuterol nebulizer rather than immediately being placed on CPAP for positive pressure

support. So these are some of the things we should continue working on.

DR. MURPHY: They are trying to get tachycardia out of that Albuterol.

DR. ARSHAD: Yeah, absolutely, absolutely. But that was the case that was referred to us, the paramedic was slightly flustered. But, nevertheless, one of the take away messages is if the code status is unclear treat conservatively and for the high acuity low occurring types of cases, especially with a critically ill patient, we need to rehearse those scenarios via simulation beforehand so when the need arises we are able to initiate treatment appropriately.

DR. MURPHY: When is the last time anyone saw a transvenous pacer being placed? I can't remember --

DR. ARSHAD: I place them.

DR. MURPHY: Do you?

DR. ARSHAD: Yeah. It's relatively easy now with the use of ultrasound guidance in regards to knowing the correct location

because the typical teaching is we attach like a V1 electric EKG spike to the device and when we see extreme ST elevation --

DR. MURPHY: We hit something.

DR. ARSHAD: -- then you know you are abutting the right ventricle, which is the appropriate location. However, in modern ages with a subxiphoid view of the heart with two practitioners you can actively view the pacer being placed and abutting the right ventricle.

The challenge though and I think one of the teaching points we have undergone with nursing staff, as well as attending physicians, is titration of your electrical pacing device. And I think when we are using a transthoracic approach many of us are comfortable or essentially can jog our memory enough to be comfortable, but especially with transvenous pacing you have to rehearse the algorithm to know in the appropriate amperage to obtain electrical capture.

DR. MURPHY: Any other comments or concerns about the case?

Proceedings

Okay, thank you, Arshad.

Next is helicopter committee. Dr. Berkowitz is not here.

Have you guys met?

DR. LARSEN: No, I've seen no scheduled meeting.

MR. HUGHES: They have no meeting --

DR. MURPHY: So that's a quick report.

RTAC? I know RTAC met.

MR. BENENATI: Not since the last REMAC.

DR. MURPHY: Wow, we are that close to the other one?

MR. BENENATI: Right before that.

DR. MURPHY: Right before that.

MR. BENENATI: Yeah, there was a TAG that was formed here as the result of the discussions from the RTAC.

DR. ARSHAD: And that was in regards to giving or helping give guidance on patient reports?

MR. BENENATI: Right, that's correct.

DR. MURPHY: Okay. QI report?

MR. CRUTCHER: The State has been rather busy in the last probably month working with

EPCR data and making sure everything has been accurate. And we have been tasked with multiple reports of issues that need to be fixed before they can move to the new bridge, the 3.4.0 version.

One of the issues was we had episodes of patient cooling post resuscitation, which we know doesn't happen, and that was a mapping error. It was an ice pack that was placed on the patient and it mapped to that. So there have been a number of issues we have been tracking down in cooperation with the vendors to get that fixed before we move to the next version and that's been occupying a fair amount of our time.

DR. MURPHY: Okay, protocol committee? Michael?

MR. BENENATI: I have nothing other than tomorrow we are going to meet again and move forward, but --

DR. MURPHY: Yeah. We have had a bunch of discussion, you know, we do a lot of electronic discussion from the collaborative committee looking at a bunch of things that

Proceedings

people have brought forward, concerns and questions. I would say a lot around oxygen, a lot around the resuscitation, when do we say we need to put supplemental oxygen on people? What kind of oxygen? And how to move forward with that, so that's about a lot of the discussion.

It's mainly been really looking at the BLS protocols though. We did some tidying up of drug dosages and making sure different protocols have the same dosage so that we keep it across the board the same, but I would say that was about it, not too much else.

DR. ARSHAD: Is there also going to be discussion regarding the AEMT protocols? I know there had been some electronic communication regarding that.

MR. BENENATI: There is, I believe, a TAG looking at those issues now that we don't have critical care any longer. I'll say we will probably take 2018 to make the necessary changes and I wouldn't suspect we would see a change until maybe January of '19. We will

Proceedings

probably work the rest of the year on these minor updates and release something later '18 or early '19.

DR. MURPHY: Okay, flying along here, guys.

New business? Anybody have any things they want to bring up?

MR. PARRISH: Morphine shortage.

DR. MURPHY: Mr. Parish, yes, I know, would you ever think there would be a morphine shortage? It's impressive each one of these drugs that keeps adding onto the list. Come on for a little while then goes out and then comes right back. So morphine, this is the first I know of coming onto the list. I was going to bring it up tomorrow, we are having a collaborative committee meeting after SEMAC. So I was going to bring that up because it's one of those things where there aren't too many -- depending upon what you are using it for there are not too many ways we can substitute. The only other thing we have on board is fentanyl, so it's a kind of sticky wicket.

Proceedings

MR. PARRISH: One of the agencies -- we don't supply them -- they called to see if we can assist them. And talking to my pharmacist she said in the hospital we are using hydromorphone --

DR. MURPHY: Yes.

MR. PARRISH: Hopefully I'm using the right term --

DR. MURPHY: Yeah, that's correct.

MR. PARRISH: So we are not in a position to help them with the morphine and because hydromorphone is not on the protocol list, that's why I brought it up here. What is their options?

DR. MURPHY: Yeah, not too many. I would hate to see us move forward and substitute hydromorphone on an ambulance. We are trying to get it to stopped being used in the emergency department because people come in and ask for it now. So you know, it's a thing where, you know, I think if the one place is, you know, when we used it for cardiac causes is the one place we really don't have a substitute, but if it's pain we

Proceedings

can definitely use the fentanyl, but it's going to be a difficult issue because we really don't have a good substitute for it.

Were you going to say something, Jeff?

MR. CRUTCHER: Nope.

DR. MURPHY: Sorry, I don't have an answer for that problem.

Also under new business, I sent to Karen a copy of the Governor Cuomo State of the State address, his proposals. And in it for the first time I know of -- Dave and I were taking about this -- is a portion and it starts on page 254, you will have the whole section to read, proposals to strengthen the rural emergency medical services system. It's the first time I've seen it directly related to EMS be that there is a clause in there. It goes on to talk about he is going to talk about promoting careers in EMS, or authorizing community paramedicine, increase the availability of EMS training in diverse settings outside of the traditional paradigm and advance materials to enhance training and leadership for leaders in emergency medicine

Proceedings

-- emergency medical services. There is quite a bit there. I thought it was pretty impressive that someone in a government position as, i.e., our Governor, talked about this. I don't ever remember it being addressed to this extent. So pretty exciting, we will see what happens. But I sent it to Karen, she will send all of you a copy so you can read it, very interesting. And, hopefully, these things will move forward. Community paramedicine, if that moves forward that will be a huge role for the prehospital provider.

Anybody else with new business?

DR. ARSHAD: I have two brief Vassar updates. So the first one is the project we are working on with Karen. We had many providers being reported as not being MACed, and that was due to a high volume of Locums physicians who are no longer active at Vassar. So we are working with Karen to get updated lists and a roster to accurately reflect that. And then there were a few stragglers we have been able to track down

Proceedings

and we will get that information to you shortly as we have also just hired a new EMS coordinator named Dave Jensen, who unfortunately could not come today because it's his first day of Health Quest orientation. But we really look forward to working with you all on any new initiatives in the coming year.

DR. MURPHY: Excellent. Anybody else?

Okay, SEMAC report?

Well, we have our meeting tomorrow on the 10th so I'll give you that report next meeting. We did do quite a bit. They asked a few of us to be on an appeal committee so we had to review a large process that occurred in Nassau County and they wanted it to be reviewed by practitioners and members outside of that area. So I was selected to be on this committee and we worked through it. We will announce our findings tomorrow. But it was a great -- it's the first time I've seen like a small committee off of SEMAC work so well and kudos to Dr. Bart, he put it altogether and I think it went very smoothly

Proceedings

and we will announce all those findings tomorrow.

In terms of SEMAC, like I said before, Lee is retiring tomorrow. Tomorrow night is her retirement celebration. It's at 6:00 o'clock after SEMAC. I forget where it is?

MR. ROBINSON: Revolutionary Hall, Troy.

DR. MURPHY: Okay, Revolutionary Hall. It's in Troy, right?

MR. ROBINSON: Correct.

DR. MURPHY: Yeah, I remembered it's in Troy. So if people want to go there is a small fee that includes dinner, gift and it is through the office for SEMAC.

Next, I have no PAD, EpiPen, albuterol, glucometer applications, but I do have some state violations.

For Kelly Almland (phonetic) out of East Islip, New York, she has a suspension for 18 months, effective December 18th. The actual suspension will be three months, the remaining 15 months was stayed for -- she is placed on probation. I guess I'm not going to be able to tell you exactly why, but it

says she has to provide an alcohol evaluation so I can only imagine what that means.

Second is Vincent Illiardi (phonetic) out of Holtsville, New York. He is under investigation, the Department of Health, and his New York State certification was revoked for a violation of Part 800.

Lastly -- Richmond Medical Center, Staten Island. The Department of Health conducted an investigation, assessed a civil penalty of $5,000.00 for violations of three areas in Part 800, so Richmond Medical Center. And it's as of this date, there is no other -- just the civil penalty.

Those are the three standing violations read into the notes -- into the minutes.

I have nothing else. Holy moly, this will be a record. Remember I said it should be an hour and a half? I think we just did it in 40 minutes -- 30 minutes.

I think what we need to do, we should have moved this meeting to next week to have all these things because, you know, SEMAC and protocol committee were all meeting after

Proceedings

this meeting so there is not much to report.

Any other open forum? Anything anyone wants to bring up?

MR. BENENATI: Maybe we should look at it for the remainder of the year.

MS. LIPPES: Next one is May after that and June 4th, so that would probably workout fine. And I think it's September after that.

DR. MURPHY: Sometimes we don't get the SEMAC dates --

MS. LIPPES: The next one you should be okay, but the next one I don't have the dates in front of me.

MR. HUGHES: Yeah, I think the dates did come out for SEMAC until January of next year.

DR. MURPHY: Okay, we will make sure to look and see if they match up.

Any other concerns or issues?

Thank you, everybody.

Can I have a motion to adjourn?

DR. ARSHAD: Motion to adjourn.

DR. MURPHY: A second?

DR. VOHRA: Second.

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

Yvette Arnold