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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, January 9, 2017, at 9:35 a.m.

Yvette Arnold,

Court Reporter

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

DAVID VIOLANTE
MIKE BENENATI
MICHAEL MURPHY
B.J. LEIDNER
RICHARD PARRISH
ISRAEL KNOBLOCH
JOHN MAHONEY
MATT NOLAN
SHARON FRAZIER
ANDY LAMARCA
JOE SOLDA
TAFFORD J. OLTZ

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DR. MURPHY: All right, everybody, why don't we bring the meeting to order? Thank you all for coming.

First thing on the agenda, we have quite a great turnout this morning, why don't we go around the room and do a roll call for purposes of not doing one in forever.

MR. CRUTCHER: Jeff Crutcher.

DR. GELLAR: Barry Gellar, Hudson Valley Hospital.

MR. VIOLANTE: David Violante.

MR. BENENATI: Michael Benenati, LaGrange Fire District.

MR. LAMARCA: Andy LaMarca, Mobile Life.

MR. PARRISH: Rich Parrish -- Rich Parrish, President of the Region.

DR. MURPHY: That's why I don't do this.

DR. WILSON: William Wilson, Northern Dutchess.

DR. VANROEKENS: Craig Van Roekens, Bon Secours.

MR. MAHONEY: John Mahoney.

DR. MAO: Dennis Mao, Good Samaritan.

DR. GUTMAN: Amy Gutman, Health Alliance

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of the Hudson Valley/Westchester Medical campus this week.

DR. BUTTERFASS: Andrew Butterfass, Putnam Hospital.

DR. SANTOS: Ron Santos, Sharon.

DR. ARSHAD: Hey, good morning, everyone. Faizan Arshad, Vassar Brothers.

DR. McGINLEY: Trevor McGinley, Orange Regional.

DR. GREENHUT: William Greenhut, Nyack Hospital.

DR. PAPISH: Mark Papish, Mid Hudson Regional.

DR. MURPHY: Pamela Murphy, Chair.

MR. HUGHES: Bill Hughes, Executive Director, Hudson Valley REMSCO.

DR. MURPHY: Okay, good morning. Thank you all for being here. Karen had sent out the minutes from our November 7th meeting. If anybody has anybody has any additions, corrections, deletions, anything, please bring them forward. Otherwise I ask for a motion for acceptance? Any corrections, problems?

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DR. MAO: Motion to accept.

DR. MURPHY: Okay. And a second?

DR. WILSON: Second.

DR. MURPHY: Thank you.

Underneath old business we are going to do a little update on the collaborative protocols. In November, as you know, the first go around was to get-together and do Hollywood style -- in the name of the Golden Globes last night, tell us, Faizan.

DR. ARSHAD: So a little bit about collaborative protocol updates, so as we discussed in November, we were planning on doing several simulation cases to help bring the protocols to life. And in regards to large scale protocol updates, there has never been an associated training protocol associated with that collaborative protocols set, so this is historic in many ways.

So part of that, we recorded two podcasts, which are produced and ready to go out regarding the nuances of the protocol updates and that's with Chris Fullagar from the Syracuse region. And the only thing we

are waiting on there is for the app. There is supposed to be an app that is available to providers on the IOS and Android that is nearing completion. So as soon as that goes live so people have a reference we will release the two podcasts as well.

And then we, over the Thanksgiving holiday, recorded a ton of simulation cases and training videos with the help of LaGrange and Arlington, including a precipitous birth and delivery in the office setting. And we complicated that by having the neonate also be a patient, so there was neonatal resuscitation. We do complex OB scenarios with all the different types of presentations regardless of head first, feet first, one foot, two feet and the appropriate management in the prehospital space done by simulation, which is exciting. I'll show you guys some video off-line related to that.

And then also a number of small sets or micro learning modules including double sequential defibrillation, which is a new on-line medical control option for ALS

providers, as well as surgical airways, which are going to be a new medical control option for prehospital care providers. So simulation on both of those things, as well as some things we don't encounter that often, like eye irration, application or placement of a Morgan lens and how to apply tetracaine for ALS providers.

And the last one was also tooth emergencies, since we don't do, as medical directors, that much CME and education on tooth related, just some basic steps on how to protect the tooth and transport it.

So those are nearly produced. We are in the phases of post production, we are adding captioning to all the videos and such. And I think that the main step is as soon as the application goes live a lot of the stuff will come through.

DR. MURPHY: Yeah, there was a few snags in the application part. Hopefully we will have good discussion tomorrow and get it all kind of sorted out. But, again, Arshad, thank you so much for all of this. This is

working out really well, it will benefit everybody in the region and I think everyone had fun. Everyone that talked to me said they had really --

DR. ARSHAD: They had a blast --

DR. MURPHY: -- a great time. And it was a great facility, a shout out to Laerdal and allowing us to use the facility, and to members of the office and the Protocol Committee, thank you, thank you, everybody that participated.

DR. ARSHAD: So one thing they asked for though and it seems we may have continued resources and funding to do simulation cases throughout the year, so if there were issues that you guys come across with protocols or things that require further education or may benefit from a case scenario or simulation, if you refer that to me I think we will be developing cases. I'm chatting with Chris tomorrow too.

DR. MURPHY: We can do trauma because I think it just doesn't happen enough. And if we could do a coordinated response and we all

work together when there is more than one group.

DR. ARSHAD: Yeah, we could do a mass casualty --

DR. MURPHY: Yeah. And have a couple patients and decide which is the sickest, which we do first and the whole nine yards. Thank you.

Narcan update. Bill, anything? Jeff?

MR. CRUTCHER: We were approached by the New York State National Guard about a month ago, they have a Counter Drug Task Force in place looking specifically at Orange County and they came in with a number of other agency representatives. We shared a fair amount of data with them and they are going forth with that to try and stem the tide.

Orange County does remain the highest in use of Narcan. And right now we are not able to get any Narcan because of the atomizer issue so we are waiting a delivery. But we have been approached by other agencies finally to get up and running with it, so we are simply waiting for the stock now.

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DR. MURPHY: Okay. And any update on the atomizer? I never seen anything else come out.

MR. CRUTCHER: Basically they said go ahead and use them because getting some of the medication is better than getting none, but the lots that we had were not affected.

MR. HUGHES: They have also sent out several recalls if you want to send them back.

DR. MURPHY: And they will replace them --

MR. HUGHES: But that is what is holding up the shipment of Narcan because they want to take care of that problem before they ship to us.

DR. MURPHY: All right. Thank you.

MR. LAMARCA: I know we had discussion about the number of EMS agencies participating. Have we seen any uptick in that? I know we had a few, that had not --

DR. MURPHY: We had a couple more, right?

MR. HUGHES: Yeah.

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DR. MURPHY: Just a couple though, no great upheaval, just a couple more.

MR. HUGHES: We are probably in the 60 to 65 percent range right now.

DR. MURPHY: Yeah, I mean, I --

MR. LAMARCA: That's discouraging --

DR. MURPHY: I think it is just such on the forefront of everyone. I mean, look at the billboards going up now, look at everything that is happening. I mean, the State is definitely focusing on it. And also, I mean, it's probably the only bill that the Senate and the Congress agreed on to put some funding towards. So it's like amazing that it's getting so many purviews, but we have to get more people on.

So anybody who has any affiliation with any of the agencies that are not part of the program yet, we really encourage you to push them forward so we get 100 percent, it would look better if we had 100 percent.

DR. PAPISH: Is there any reason people cite --

DR. MURPHY: No one has come forward to

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say, you know -- I think fear is, but it's like you don't have to pay for it. We are going to help people out, but I don't know.

MR. HUGHES: A lot of the feedback is everybody has it, so we don't need it.

DR. MURPHY: Oh, so they think they don't have to because the police and first responder and fire --

MR. HUGHES: Right.

DR. MURPHY: So if we can just keep trying to get people on board, it would be great. I think we should be the forefront there.

Okay, under service upgrades, last time I mentioned the issue with Arlington. We have now a weigh in by the State. And all -- I had sent a letter for -- giving them support from this office and from the Region.

And, David, I'll turn it over to you if you want to enlighten everybody because some people are not going to know.

MR. VIOLANTE: So in the past six months the Commissioner of the Arlington Fire District have adopted the idea to move toward

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ALS first response agency and not do transport in contract with a transporting agency, which are we entered into a contract with Mobile Life to do that transport work. That's been working very well.

So in moving from an ambulance agency to ALS FR not doing transport required a service agency change. We went through that process as municipal CON with the State. Part of that was coming to the REMAC to get approval for ALS practice and privileges for paramedic staff, which we started the process with Pam so we could work through that with the State and get things moved for a January 1st date, which for us ended up being a contractual deadline, which is why we ended up going through Pam. It's not really a back door, but a way to get things done.

Subsequent to that we have been in talks with the State and others, they would -- they have encouraged our board to keep our ambulance operating certificate and maintain it, at least for the short-term. So that we can -- if anything happens in the system for

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any reason we are covered and can continue to practice providing ambulance transport should that ever be a necessity in the near future, at least for one certification cycle, which is two years. So what we would like to do because we have the approval for the ALS FR, is to maintain that approval here at REMAC in conjunction with the ambulance operating certificate which, per the State, we are allowed to have. There is nothing we have to do for the ambulance operating certificate that maintains in force.

DR. MURPHY: And the State wanted you to maintain ambulance indefinitely? Or they didn't really --

MR. VIOLANTE: They suggested we hold onto it for at least one certification cycle to make sure everything in the system is plateaued out and has worked and is operational and functional and no huge hiccups, problems, issues, anything like that. Once we have gone through that time frame we can make a decision then.

DR. MURPHY: And so you had to modify

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your narcotics plan, right?

MR. VIOLANTE: Our narcotics plan largely remains the same. The only difference is -- that we have now is we have added a new agency number to our system. Our narcotics plan is the same, controlled substance is the same, policy and procedures remain the same, and the only operational difference is we are not transporting on ambulances. We have paramedics doing first response and Mobile Life is transporting all our patients.

DR. MURPHY: So we don't have to vote, there is nothing to vote on.

MR. HUGHES: We have to vote on the BLS FR --

MR. VIOLANTE: ALS FR.

MR. HUGHES: I'm sorry, ALS FR.

DR. MURPHY: So do you want to make a motion?

MR. VIOLANTE: I cannot.

DR. MURPHY: Oh, that's true.

MR. VIOLANTE: I do appreciate that --

(Everyone is speaking at once.)

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DR. MURPHY: So I'll make a motion to approve Arlington Fire to have the ALS FR designation as first responders and it's just a kind of change in the way that they respond to their calls in that district. They will retain their certificate for the ambulance agency for now so that will not change.

Any questions?

DR. WILSON: Sorry, are you saying you go as an ALS responder and then when Mobile Life goes to transport you hand the patient off --

MR. VIOLANTE: Correct.

DR. WILSON: -- or does that provider ride on the ambulance?

MR. VIOLANTE: We turnover care to Mobile Life paramedic.

DR. PAPISH: Unless it's BLS. You would ride if they accepted BLS because they can't --

MR. VIOLANTE: In that case our paramedic jumps on board and goes with it.

DR. MURPHY: Provided it was ALS.

MR. VIOLANTE: Provided it was ALS.

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DR. PAPISH: Second.

DR. MURPHY: Second. All those in favor?

So I have unanimous. Thank you, everyone.

MR. VIOLANTE: Thank you.

DR. MURPHY: Evaluation Subcommittee report?

DR. ARSHAD: No new cases to report.

DR. MURPHY: We got one on Friday, we will talk afterwards. It just came in Friday though.

Helicopter Committee report?

DR. BERKOWITZ: Nothing to report.

DR. MURPHY: RTAC.

DR. BERKOWITZ: I don't think we met since last time.

DR. MURPHY: I don't think so either, there is a meeting scheduled.

DR. BERKOWITZ: Do you know the date? I'm trying to look, but it's not showing up.

DR. MURPHY: No. There was controversy so it went back and was coming back out again. So nothing happened since the last --

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DR. PAPISH: What is going on over there? Is there like new -- Marie left?

DR. BERKOWITZ: Marie left so Dr. Lombardo is the head --

DR. PAPISH: So he is just kind of stepping in?

DR. BERKOWITZ: Yeah. He was kind of associate -- for lack of -- probably the unpaid associate for a while, but now he is doing all the trauma, medical director stuff.

DR. MURPHY: Jeffery, quality improvement?

MR. CRUTCHER: The biggest thing going on for this the first quarter is Image Trend will be here January 23rd, 24th and 25th. They will spend a half a day with me going through the updates to the new Elite bridge, the Nemesis 3 compatible bridge.

The 24th will be at least two informational sessions for agencies considering going via EPCR. We don't have the involvement of setting those up, the sales staff from Image Trend is doing that.

And on the 25th we will be doing a

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couple of hospital site visits to discuss the flow of data back from the hospital to the regional bridge that Image Trend blessed us with. So that we would be able to make a much better -- be much better for data mining, for any complaints that come in, we would pretty much have a real time report of the data coming in. One of the provisions of Nemesis 3 is that reporting will be done essentially on a daily, hourly, minute by minute basis. So that as a document is uploaded, we will see it, which is going to be a big boon to anything that we want to do as far as research.

And that's about it for now.

DR. MURPHY: Yeah, it will make it so much easier --

MR. CRUTCHER: Yes.

DR. MURPHY: -- so you can just pluck the data out.

DR. PAPISH: They were providing a cost effective way of getting on-line, right --

MR. CRUTCHER: Yes, they are.

DR. PAPISH: We talked quickly, what is

the cost roughly for an agency.

MR. CRUTCHER: If it's a BLS agency it runs about $0.75 for a PCR. So if it's a small agency that is doing 100 or 200 calls a year, that's fairly affordable. The hardware platform is now fairly agnostic so you can use an IPhone, an IPad, an Android tablet. The only thing you cannot use is a Kindle simply because Amazon built in such security restrictions it won't work. The days of having to use an $8,000.00 Toughbook are gone.

DR. PAPISH: ALS?

MR. CRUTCHER: ALS is about a dollar, dollar fifty, depends what you have to upload. So it's extraordinarily affordable. They also have now a module for mobile integrated health care, which will allow agencies to be more specific with that documentation, so it's quite robust.

DR. PAPISH: We may have to -- the reason I ask --

MR. VIOLANTE: Sorry, go ahead.

DR. PAPISH: -- you know, we all talk

about like having RSI and advancing -- sort of advancing what we do in the field, but we have very little data on our efficacy or successful intubation rates and being able to data mine is so important. But only what percentage of our agencies are line now, like 40 percent?

MR. CRUTCHER: It's fairly low, a little bit lower than Narcan.

DR. PAPISH: So, I mean, this way we will be able to get the accurate data about what is going on prehospital.

(Everyone is speaking at once.)

MR. VIOLANTE: So we talked at a number of different -- especially Dutchess County -- of actually getting the data into the hospitals from prehospital providers and it sounds like this is a potential way for that to happen. Will any agency using any platform have to upload to this platform for it to then work for the hospitals, or will they be able to get information from the provider at the point in time of service to whatever hospital they have gone to?

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MR. CRUTCHER: Essentially the hospital receiving facility will have a dashboard they can use. So it doesn't matter if you are using ESO AmbuPro, it doesn't matter, Image Trend is able to take that information and put it into language that the receiving facility needs.

MR. VIOLANTE: Is there a cost for the hospital to do that?

MR. CRUTCHER: That I'm not certain of. There is always a cost associated, but when you consider what you can do with the data as well as what you can do with mobile integrated health care and using that data to prevent early readmits, for say, CHF patients, the hospitals will recognize the --

MR. VIOLANTE: We have had so many discussions about not getting PCRs at the hospitals and data and information, maybe this a way around that.

DR. PAPISH: Hospitals all need this data now. Any trauma, any stroke, we need prehospital notification times, that's it, for the next reporting year, for a lot of the

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stroke -- coverdell, the various stroke agencies.

MR. PARRISH: I backup what Dave is saying. Getting PCR, even electronic, they don't send it. We have one agency that is on Image Trend and they want us to sign on using a password and I'm not going to do that for every agency, sign on with their password so we could download it and they refused to send it to us.

DR. BERKOWITZ: I think that's a good point, if hospitals would be downloaded we have to make sure one hospital -- we receive from so many different agencies I would imagine if every agency had to use a different login for the PCR, I could never operationalize that, but if there was one central login that I could operationalize and remove and make that work. So I think that's a great point.

DR. MURPHY: Will they not do that because of financial --

MR. PARRISH: Image Trend supposedly told them for them to transmit to us there

would be a service fee for that. And that has got to go away. And we have really got to, you know, push getting the PCRs. There are still agencies out there doing --

DR. PAPISH: I mean, it sounds very -- like maybe it's not legal, but if Image Trend was to --

(Everyone is speaking at once.)

DR. PAPISH: -- supplying us with the data and we had a HIPAA relationship with the hospital entity, would we be allowed to share our information that we received from Image Trend in some secure manner with the hospital?

MR. CRUTCHER: As long as it follows HIPAA requirements.

DR. PAPISH: Maybe Image Trend would sue obviously, but it's sort of a way around that.

DR. MURPHY: The only problem, it won't be real time, but it would be definitely good for reporting and statistical and just review, but it wouldn't be real time.

DR. PAPISH: Well, we'd have to --

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DR. MURPHY: Yeah, for keeping track.

MR. PARRISH: Jeff, you mentioned that they were going to put the data in a way that it could blend into the hospital report?

MR. CRUTCHER: It would be integrated into the patient's record.

MR. PARRISH: So what was it --

MR. VIOLANTE: HL7 --

MR. PARRISH: -- HL7 is an issue right now. They don't blend together, they are two different languages. And there was supposed to be a program that permitted that to happen. So if Image Trend has that what about other agencies that have different programs?

MR. CRUTCHER: Image Trend has that capability. There are other software vendors out there that claim they have the capability -- and they don't.

MR. PARRISH: And I would say in my county it's a mix, 50/50, you know. I think I got half of them are on Image Trend, the other are on other products.

DR. MURPHY: Mike?

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MR. BENENATI: Is this is a Statewide initiative that Image Trend is coming around to the regions --

MR. CRUTCHER: No --

MR. BENENATI: -- or are you inviting them?

MR. CRUTCHER: -- we have a good working relationship with Image Trend.

MR. HUGHES: They are supplying the regional bridge for us, that's why we are dealing with Image Trend. Not that they we are trying -- but for us to get the data it comes off of the regional bridge will be for the State. And what the regional bridge is everybody's information that now is sent to the state bridge will come to the regional bridge and then the regional bridge sends it to the State.

MR. VIOLANTE: All of the other providers have to send their data to the State through Image Trend so they have a connection. We tried working this with ESO with hospitals because they have a converted HL7 and that works with most other agencies.

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They are trying to work out some of that now, but it comes from the State bridge where the information is supposed to go up for Nemesis. It maybe a good --

MR. HUGHES: But we are talking Nemesis 3, which is the next version. So all the software out there today is only two so it all has to be upgraded.

DR. MURPHY: All right, any other discussion? Thank you, Jeff.

Protocol Committee? Mike?

MR. BENENATI: Thanks to Dr. Arshad and the team that the filming was outstanding. I think when you see the quality of the video you'll be really pleased. This is a great statewide initiative, very very hard to believe we have been able to pull this off, just phenomenal.

And a few other components, we did a severe hemorrhage, I know you were talking about trauma. And then we also did two quality improvement scenarios. One was a formal debriefing in classroom environment with a medical director and the other was

informal, standing in the back of an ambulance, both helped people understanding what should be happening after the calls -- kudos.

We are still looking at the collaborative rollout process. We will know more this week. I'm sure tomorrow afternoon we will learn a lot more. There is a push to get protocols out there as soon as possible. The app seems to be the thing that is holding the process up, but we want to keep that moving.

We are also hoping to offer an online exam for paramedics to upgrade. And Bill is working -- Bill and Jeff are working to see how we can do that, maybe if we can piggy back on with another region, but certainly having a method to do that would make this easier for us.

With this process a number of the policies were removed from the protocol because these are now medical treatment protocols. So the Protocol Committee has been pulling those policies apart, reviewing

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them, updating them as appropriate and Jeff is incorporating those into the policy manual. And so we will continue to have those, but they will be revised and we will put them as part of the policy manual so there is still more to come on that. And that's items such as special care transports, rehab, the helicopters --

MR. LAMARCA: Physician unseen.

MR. BENENATI: -- physician unseen, stuff like that.

The other new topic that came up that we wanted to bring here today is some diversion issues that we have been seeing in the region recently. From our perspective we think that there are really three key components for discussion. One is from a dispatch perspective, we want to make sure that dispatch centers are aware of hospitals that are on diversion so they can forward push this information out to EMS providers upon response. What often times happens is that an EMS agency and crew is not aware that a facility is on diversion, they make a

decision with the patient without any knowledge of diversion, family starts to go, somebody's on a cell phone calling somebody else to go to a hospital because somebody is taken there, the patient gets loaded in the ambulance, the ambulance calls en route to that facility and the dispatch says, be advised that facility is on diversion. That creates a challenge because now there is a disconnect with the family and decisions meed to be made at last minute. So certainly as we talk about diversion here hopefully today that is something that we can consider.

The second is from the EMS providers perspective. One certainly is, providers need to encourage patients that they should go to a facility where they can get more timely care. We all know that diversion is a request and not a requirement. However, a patient who is transported to a facility that is on diversion may see a delay in the care that is received. But we also then need to understand that, ultimately, it's the patient's decision. If they want to go to

that facility, they have that right. They should be aware there maybe a delay in patient care when they arrive there. But we always run into the challenges from staff when we do roll in, that, well, didn't you know we are on diversion? Yeah, we knew that. So education at a hospital perspective.

And then certainly from a hospital end of this, types of diversions allowed. Specifically specialty diversions, are we on trauma diversion? Are we on stroke diversion? Are we on CT down diversion? Are we down -- on diversion simply due to patient volume?

And then, how do we monitor diversion? How do we know within the region what facilities are on diversion, which facilities are off diversions? Are they checking in every six hours with dispatch centers and integration of all this.

So diversion is a significant issue and seems at this point to be peaking a little bit. So we were asking that the REMAC would

address some of those issues today.

So I'll turn it back over to --

DR. MURPHY: Is that because I'm part of Orange Regional?

MR. BENENATI: No, because I think it says chair there --

DR. PAPISH: Also there has been record volume --

MR. BENENATI: No -- and it's not one facility. We are not asking a lot. I want that to be very clear. We are seeing it across every facility and different dispatch centers are handling it different ways and there is no coordinated approach.

DR. MURPHY: Yeah. I think the first thing is the communication to the 9-1-1 centers. What happens is when the hospital requests diversion it's a finite time, two hours, four hours, depending what they question. And you do it short segments so that you can revisit it and see what have they done since the diversion went on. They are supposed to communicate it to specific centers in their region so that, you know,

the center is abreast of what they just requested. Unfortunately, that don't always work. And, unfortunately, it doesn't communicate out there so people are making transport to an institution that is on diversion. But it is really a courtesy and if somebody really wants to go there the hospital has to take the patient, there is no question.

I think that what Dr. Papish just brought up -- now that I'm administration at Orange Regional, I can tell you -- the other day my volume was 384 inpatients, that's the maximum that institution can take. I still had 24 in the ER that were admitted. So it's like, what do you do? It's a very -- I have seen volume like this actually in my 25 years of doing this. So I think this time of the year is always bad, but I think -- I want all of us to be the real educators of what diversion is about and we have to start with our departments. Because I think they can't greet prehospital providers with, don't you know we are on diversion? That's

unacceptable. You know, it's a thing where we have to take care of the patient. We have to remember there is a patient on the stretcher. You know, if people are fighting about what happens it just looks horrible and imagine what the patient and family feel like.

So I think it's all education. And I think it's unfortunate that it's happening, but this is just going to be an astounding flu season and we are just really starting. They are reporting like major deaths from this flu. There is one institution actually in France yesterday that reported 30 cases, 13 people died out of those 30. So it's like a very virulent form, it's going to be worse than last year -- and these were people that were vaccinated. So it's a thing where we are only starting to see, I hate to see what the next 30 days is going to be. But I think we can all be advocates to educate and pass the message forward. I don't know why the communication falls between the institution and the 9-1-1 centers. I don't know what

happens there. It's pretty much straightforward, it's a call, you say, it's is a time frame, it's allotted and it's addressed in that time frame. Generally there should be a back and forth communication between the center and institution. They call and say, hey, what is the update? How are you guys doing now? In that time frame.

Types of diversion are going to occur because of what a facility's institution has and if they do lose their scanner, we have had to deal with that at places at times. And they definitely have talked about alternative fashions, like being on diversion for strokes if the CAT scanner is down, or for one particular treatment entity if they don't have the capacity to take care of the patient. But diversion is something to keep a hold on, it's certainly no good for our hospitals, it's certainly not good for providers and not good for our patients so it's a lose all the way around, there is no question.

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DR. VANROEKENS: A couple points. One, to my knowledge diversion is not an option really in terms of can you request diversion, but basically --

(The speaker cannot be heard.)

DR. VANROEKENS: -- which are the requirements for diversion. There are real things that occur, operational issues with CT scanners, volume, and acute issues with flu and other surges in volume, but I think that that really needs to be monitored. And I would request that we actually track the hours of diversion across all the hospitals. I think that's really -- hospital, ours in particular, has been on diversion, I think, a fair amount.

DR. MURPHY: It's crazy, they are having an emergency meeting this morning about it.

DR. VANROEKENS: Previously I worked at an HMO, they went on diversion. And they did that to prevent certain patients from coming -- which was essentially illegal. It was California, it didn't really matter. There is no Department of Health that oversaw

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health care operations in California. We, I think, have a different viewpoint in New York and try to cooperate with all the hospitals, EMS, and try and make sure the right thing happens.

I can tell you the small little hospital I'm at, St. Anthony's Community, we don't have the ability to do hemodialysis and if we get patients with hemodialysis issues -- that's an issue. EMS is responding appropriately, I think, for requests for diversion, but I think it's important that we think about the patient and what makes the most sense. So I request we actually monitor that and be able to report that. I think the 9-1-1 centers could do that.

DR. BERKOWITZ: Yeah, you know, Westchester County struggled with this for a while. And I think the beginning of improving it was starting to monitor the hours and having real concrete numbers that we would go through every month. You know, initially -- it was identified initially so people know what is going on. And I think

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that everybody agrees the only diversion we are talking about that impacts the system is a general diversion. Specialty diversion in my opinion is generally acceptable and understandable, but general diversion is what causes the biggest problems and causes issues where you have high volume and you guys have high volume and now you have to drive further with high volume. So you have less capacity to transport patients because patients are waiting. So it's this awful cycle that delays and delays and mucks up the entire system. So the first thing we need to do is to start monitoring --

DR. PAPISH: So the barrier -- Westchester was easiest because there is the Westchester 9-1-1 center basically dispatches all of Westchester and what areas it doesn't, it still has oversight. We have a lot of counties and lot of dispatch centers --

MR. HUGHES: Yes, we do --

DR. PAPISH: I'm assuming agencies have their own -- how do we coordinate --

MR. BENENATI: I think one of the things

that Bill was going to try and do and did send out an e-mail -- and Jeff certainly has been involved as well -- is try to pull together the EMS coordinators first to get them a part of this process. You know, we have one representative here today, one county represented here today, we should have more represented at this table to take this information back. And he is trying to integrate 9-1-1 centers into that as well so that we can start to share this information because it certainly it does have significant implications.

The other thing that I think we spoke about at the Protocol Committee is asking Jeff to pull together an informational document so we can start to talk and get this in writing so we can share a consistent message. I think that's also important, so people understand what it is.

How to track? That's a big issue. And, you know, we did discuss that a little bit and maybe that is sending an e-mail to the region to say when you are on and off and so

that there can be a tracking tool, but somehow at the regional level we should be tracking this. And Pam talks about a specified period of time, you know, do we even standardize that? Do we say, you know, you can be on diversion for a few hours and then you have to check back in. Or if it's an equipment diversion, you know, you are not going to get a CT scanner fixed in two hours, in that case do you make it a 12 hour notification? So just, you know, I think it's a huge complex issue that we are not going to solve here today but if we start putting components together to resolve it that would help.

DR. BERKOWITZ: Yeah, Westchester has a great system for tracking. I think that's how they got the numbers. I don't know if there is a way to boot strap on that, we can talk afterwards.

The other thing I wanted to mention just in terms of some of the other considerations we are talking about, every hospital has a diversion policy. And we should make sure

diversion policies -- make it clear to staff, that patients that want to go to facility, you can't turn them away. Our language is if they are unwavering -- whatever, you know, policy language is in there. But also make sure you take into account what your role is in your region. If you are the local STEMI center, or the only place around that does dialysis, or whatever it is, that you are going to take that into account. I know ours is if it's peds, peds burn, peds trauma, you know, peds, peds, peds -- but a lot of stuff, really avoid diverting those patients at all costs. But a lot of hospitals have different roles in their regions and it's important they acknowledge those roles. Even if it's like the hospital that has more mental health, or whatever it is, whatever you have should be taken into account in the hospital diversion policy.

MR. PARRISH: Westchester dispatch center has a program that all the hospitals have been trained on to key into it and blast it out to all the hospitals. And I think at

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the last meeting we had there was a discussion about getting the dispatch centers on-line for that, but right now a lot of the hospitals aren't using it. The ones down, the south, Westchester and those areas are using it, but I know my facility, they have got the code to get into it, but they don't post it.

DR. BERKOWITZ: I think it's -- I think there is no cost -- don't hold me to that. I think that the one thing, because it does work, would be if we were to say that, you know, in order to go on diversion you have to go through that system. That would -- and it's very easy to use, I've taught a bunch of people to use it and if we did that we'd automatically have all the data we want. It's not requiring -- it's not saying -- it's not saying you can't or cannot, it's not doing anything, it says this is how you go on --

DR. PAPISH: It's web based --

MR. PARRISH: Web based and it sends you a reminder every couple hours, are you still

on diversion? So you have to update it. And I don't think it would be an issue getting the dispatch centers access to that.

DR. BERKOWITZ: So I'll talk with our program coordinator later today about this. I think that we can't do anything without data. And just from the -- aside from the flu thing, from the emergency management perspective, technically every hospital should be able to take 20 percent more than they are listed beds, clearly that's not the case. I know we have opened additional units and other spaces being converted now and I don't think we are going to make 20 percent at this point. But it concerns me because, you know, this means if there is a really bad event we'd have a real hard time addressing the patient needs.

MR. LAMARCA: I think over the years we have seen a number of hospitals deal with diverse issues in different ways and have to have diversion plans. In some cases I think administration says, that's it, we are not going to divert. The orders come down to ER

and just don't divert anybody. You could have six patients on stretchers and six ambulances in the parking lot because they can't leave and they have no beds. So we have urged judicious use of the diversion when necessary.

And I second Dr. Berkowitz's opinion about the responsibilities and -- but also I think one thing you have to realize is -- this is something we discussed at the State level and will probably discuss again over the next couple days. EMS is probably in the worst shape it's ever been in. The state and every -- bordering on crisis here locally. I can tell you, as you one of the larger service providers, we have a number of services, one and done. They take one call there is nobody to backup if they are diverted from a close hospital to further it's further time on task. And it's not just the volunteers who it does affect. A lot, every day we probably respond and backup areas serviced by another ALS provider, like four or five. We are just trying to cover as

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much as possible and on a daily basis the system is failing. The more we go to diversion and push units further out --

(The speaker cannot be heard.)

MR. LAMARCA: -- you know, we try. And I think most of them do a very good job of saying listen, it's in the patient's interests, convenience, to go further away so they are not there for six or seven hours, they can be out of the hospital in two hours. They do a good job of that, occasionally they don't want to go and we bring them in and the staff takes exception. The hospitals have to realize that now diversion is more critical, that previously superimposed -- you know, increased flu season, this system is in dire shape. We have communities with no ambulance available for a long period of time, no backup available from four services when we had cardiac patients. We can't tolerate many more diversions and still get to these people in reasonable time.

MR. VIOLANTE: I'm not sure if everyone is totally aware that this happens and so I

want to say this because it's not totally out there. To really bring forward Andy's point of criticality is that in each county we have heard increasing number of times that the dispatch center has to call a patient back and say, there is no ambulance coming. You are going to have to find a way to the hospital if you really need to go.

And so that's the level this is at -- that's not to say it's because of diversion. I don't mean to say that. There is a lot of complex issues involved in that from system perspective, availability, volunteers, career, combination of things happening. You know, one ambulance only in a community where they really need two or three. A lot of this ends up being a number of factors from financial to social to, you know, a variety of things. And so that is happening, where people in the community are not getting the services that they need and this is a facet of it. So we do need to work on this in a variety of ways.

MR. BENENATI: Two final comments, one

is just a pig tailing on Dave's. That really came to light I think at the hospital level recently when we were at a STEMI meeting -- we go to monthly STEMI meetings at Vassar -- and they are talking door to balloon time and what they forget to consider is that it took 45 minutes for an ambulance to get to the patient in the first place. And so all of the hospitals always need to take that into consideration. You think that somebody is accessing 9-1-1 and there is an ambulance at their door in four to six minutes and initiating a transport right away -- that's really not happening. In some communities certainly it is, but in a lot of the areas it's not happening.

And then two is, you know, how do we keep this diversion topic alive? I don't know if you want to create a TAG to manage this because this I think is something that needs to be, you know, managed intensely here over the next month or Protocol Committee has already started, do you want them to develop some stuff to push-up, that structure is

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already in place we are already on that committee, the two of you are already on that committee, certainly others can join us. I think we need to keep it alive.

DR. MURPHY: I think the easiest would be just with protocol because you are already there, we already have a committee and a system setup.

That's the first I am ever hearing of a 9-1-1 center calling back the patient to say there is no ambulance to come pick you up.

MR. LAMARCA: Multiple times in Orange County and Ulster --

DR. MURPHY: Orange and Ulster?

MR. VIOLANTE: It just started happening in Dutchess.

MR. LAMARCA: We have patients brought by private vehicle --

MR. BENENATI: So that goes on to the -- we really need to get -- and I stressed this to Bill a number of times -- we really need to get our EMS coordinators involved in this entire process. There seems to be a disconnect and I think it's the

responsibility of the Region to start bringing EMS coordinators into this process and communicate with them.

DR. MURPHY: Yeah, I think the only one I have ever seen in my career here is Dutchess. I think that's the only time anybody every comes, right?

MR. VIOLANTE: We do have an EMS task force in Dutchess looking at this particular issue --

DR. MURPHY: Yeah, I've never seen anybody else come.

Do they have a responsibility to the committee? Is there any part that they have a responsibility to be here or is it just our request?

MR. LAMARCA: No, it's a request.

MR. BENENATI: It would be a request. But, again, they should have our conduit. We, as the Region, oversees all EMS agencies at all levels in the Region. Certainly we come to these meetings because we do this full-time, but we would not expect all of the captains and managers of all the agencies to

be able to attend this meeting. The conduit of information from here to them should be through the EMS coordinators or medical directors. And you can see that when you -- if you were to map this out in your mind, you would see why we have that disconnect. We talked about -- Bill talks about we have 60 percent of the agencies offering Narcan. I'd like to see a chart of every single agency and what additional capability they have. But, again, we need to communicate. Bill has been pushing for a number of years to -- when we do our recertification process, which we must go through every two years, we mail into the State our entire packet of state-mandated equipment -- of information. That information never even gets passed back down to the Region. So Bill may not even have who the service medical director is or who the captain is of an agency updated every two years. And we have been pushing the State for sometime to get that stuff. So Bill is in a situation where he doesn't even know what agency contact information is. We

don't have a method of sending an e-mail to every EMS agency in this region because we don't have a current list -- as crazy as that sounds.

DR. MURPHY: Rich?

MR. PARRISH: EMS coordinators do have a seat according to bylaws on the Council.

DR. MURPHY: Yes, on REMSCO, right. They have the council so they show up there, right?

MR. PARRISH: No.

MR. HUGHES: Well, some do --

DR. MURPHY: Yeah, that's where I would see more --

MR. PARRISH: But they have, I believe, a non-voting seat.

MR. HUGHES: Unless their county has elected them. I believe we have four county EMS coordinators that do have seats on REMSCO and the other two don't, but they are members of REMSCO by bylaws.

MR. LAMARCA: Just related topic and not one really in the purview of REMAC, but something that does affect or could affect

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diversion, that is we really need to push at the State level two topics. One is treat and release and the second is alternate destination --

(The speaker cannot be heard.)

MR. LAMARCA: -- there are some patients inundating the ER that don't need to be there. First of all, they don't need any care and there are probably some cases -- and with proper controls we might be able to do something if we could treat and release in the field.

And the second thing, alternate destination. Right now an ambulance has to take to a hospital. If they don't need to be there could they go to urgent care or to a clinic? Yes. And we are getting nowhere. I initially thought the change to Article 30 might help us and nothing has happened. We have a little group again that are trying to push the State to take a patient, drop them off at urgent care, below gravity level that you go to ER, that would help. Right now if they have health insurance they don't have to

pay the deductible, but once they are on the ambulance we can't go anywhere but a hospital. We have to change that. If we don't, we are going to load you up with people that shouldn't be there.

DR. PAPISH: Currently there is one facility opening up in Dutchess, they asked for Article 28, the mental health thing, that is opening up --

MR. MAHONEY: -- stabilization center.

(Everyone is speaking at once.)

MR. LAMARCA: Can they do medical clearances?

DR. PAPISH: They don't have the waiver yet, but the idea being they would be Article 28 waiver so they could receive ambulance for mental health crises and intoxications.

DR. MURPHY: Who is doing that?

DR. PAPISH: It's a county collaborative.

MR. LAMARCA: I don't know what REMAC can do except to lobby on our behalf to try and get the State -- we will probably discuss this, Lee brought up the crisis issue last

time and it's only gotten worse. We think we are bad? Take a look at the rural areas Upstate and how people are just -- there are no ambulances.

MR. VIOLANTE: I do not suggest Uber.

DR. MURPHY: Medical Uber? Maybe we are on the idea of something.

So I think it might be an issue for the coordinators because they probably have full-time jobs and things like that and going to REMSCO -- I don't know, we will have to talk about it.

MR. VIOLANTE: For these guys also is that when they go then to the county, either Medical Advisory Committee meeting at county level or County Council meetings there is not a lot of participation at those meetings from the individual corps and agencies that makeup that contingency. So even if something is put out here that they get and it goes to that meeting, it's the same people that you see at every other meeting, you are not reaching out to the agencies and organizations.

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MR. PARRISH: There is no teeth out there. The EMS coordinators can suggest stuff. A lot of the BLS -- I know it was brought up when Lee Burns was here at the REMSCO meeting. We have some control over ALS agency, but the BLS. When we started talking about it, you know, turn it over to Kevin Gauge to go out and let him monitor these agencies. But we have no control over the BLS agencies. I know in my county when I was EMS coordinator, you talk to them, we don't have to do that. They think they are a stand alone agency that they don't have to integrate with anybody else. You talk to them about, you really should be talking to your neighbors and -- dirty word -- consolidation, they don't want to hear it. They think, hey, we are here, we will respond when we can. When we can't, Mobile Life will back us up. Mobile Life doesn't have the resources to backup every agency. And my concern is we don't have any teeth to go after these agencies to make them improve.

MR. LAMARCA: Here is a choke point,

every agency in the State of New York has to have a medical director.

DR. MURPHY: That's what I was going through -- you saw inside my head. I think, as you know, there are some medical directors more involved than others and some -- just as bad as Bill not knowing who the captain or head of any agency is -- sometimes the agency hasn't talked to their medical director and don't even know if they still practice.

MR. BENENATI: With the exception the medical director needs to sign that form every two years for the agency and if Bill were to get a copy of that he would get that information, but the State at this point does not push that information down.

MR. PARRISH: And some medical directors, they think they are doing a community service by signing off and you can talk to them -- in the two agencies in my area that don't do Narcan, I personally know both the medical directors and talked with them and they still don't do this, even though they support it.

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DR. PAPISH: The other choke point, the town government, or village, you would think --

MR. PARRISH: No.

DR. PAPISH: -- by the way, your ambulance doesn't perform --

MR. LAMARCA: A lot do not want to know about it because they are not funding them and as soon as you pay interest, you have to fund them.

MR. PARRISH: We started the Ulster County EMS Advisory Board. Oh, man, we are really going to start. And a couple of the legislators sat and the whole bit, when we started talking we need to go out and meet with the Town Supervisors, the Board stopped meeting. They didn't reappoint it.

MR. BENENATI: So David certainly could speak to it more, but I think there certainly is a lot of ignorance out there at all levels from the general population up to elected officials. I think we should stay tuned and watch the Dutchess County report when the report comes out. I know the goal is in the

very near future, within a period of a few months. I think you could take that report and put any county name on it and it's going to be the same. I think we should wait and watch that report and -- just to end the topic because we could talk all day about this -- there have been statewide conference calls going on run by the SEMSCO President to start to talk about some of these issues at a statewide level. And so this is huge. We are in critical condition, as Andy says, and we need to acknowledge that and try to be a part of the solution.

DR. MAO: I agree with everything you say. I've asked in the current EMS -- at least some of the courses some are still trying to do Narcan and Epi, they have great ALS backup, but the others are volunteers. The EMS system has no support, that is it's not that we are not providing it, they have support internally for them. There are not enough members or volunteers, they are barely able to get the rigs out to pickup patients. To go one step further, on management part,

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they can't -- you guys are paid. You have paid supervisors. These people have full-time jobs. As much as you want to --

(The speaker cannot be heard.)

DR. MAO: -- we are short. Further north, I don't know how they are doing it. You are talking an hour, two, three, four hours in good weather, forget about a blizzard. It behooves us to find ways to support -- maybe, Dr. Arshad, you have a great system with the iPad cast -- maybe setup something where, for example, for the Narcan, get a module so the medical director can say, we have this great thing, have CIC sit and make sure they watch and provide support. They can't get the --

DR. PAPISH: There already is a module --

DR. MAO: But something else of -- the check and eject, if we get the modules in place for them and support them it will make it easier to get on board. They are fighting to get the rigs out, look at the transport times on your end. If we support the Epipen

and Narcan to streamline it, it would be a huge support.

DR. MURPHY: Yeah, I think the volunteer aspect of it also is huge. I think that's one of the things that, you know, we can't get enough volunteers and people to staff the ambulances and be able to be responding for a call. It's --

MR. PARRISH: Another thing -- and I don't know where it is -- but there was a law -- or proposed law about making EMS an essential service and whether or not that is, we need to get on board with that. Because that's why communities don't mandate anything, don't fund it. Police and fire are essential. EMS -- a community is required to provide EMS, it's not an essential service.

DR. PAPISH: When was that law?

MR. LAMARCA: It's current legislation, it's not been voted --

MR. MAHONEY: Sitting in the committee last time I checked.

MR. LAMARCA: We will probably hear about that over the next few weeks.

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DR. MURPHY: Okay, thank you, everyone.

Do you want to do the -- under new business, anyone have anything they want to bring up this morning?

DR. GREENHUT: Sepsis. I have been approached by some forward thinking paramedics, particularly from Hatzolah, that are interested in implementing point of care lactate, and wondering if there are other agencies or regions in the hospital that utilize that for clinical decision making prehospital setting and adding it to the hospital protocol.

DR. MURPHY: No one talked about that yet. However, the Collaborative Committee is working on a sepsis protocol. I think it is huge because if we can identify these patients sooner rather than later, this makes a big difference, it affects mortality and morbidity. Next to drug overdoses I think that's the -- the narcotic craziness, that's the biggest thing also on the plate is to deal with the whole sepsis issue and we are not doing such a great job. And so I don't

know about the lactate testing. I don't know if anybody has used it.

MR. OLTZ: The last one I heard of -- and this was years ago -- is when Stat Flight was still around, not when it was.

(The speaker cannot be heard.)

MR. OLTZ: -- and they were doing a pilot program of testing lactate levels --

DR. MURPHY: Point of care testing.

MR. OLTZ: Since then I have not heard of any prehospital agency doing it.

DR. BERKOWITZ: I think there was an either ongoing or recent trial of it, I think mostly for trauma. But either way, I think that there maybe at least more data than many other things so that should be looked at.

DR. GREENHUT: I guess if we are able to implement that we should collect data and I can report back to --

DR. MURPHY: Who is using it and what their efficacy is. I'll get for you what is developed so far an the protocol they are working on. I'll get that for you.

MR. BENENATI: If you have some forward

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thinkers who want to -- I mean, a lot of this really is research so if they can come up with some proposed protocols as well as supporting documentation which supports that, I'm sure we at the Protocol Committee through Dr. Murphy can push it up to the collaborative for the next release.

DR. GREENHUT: Excellent, thank you.

DR. MURPHY: Any other new business?

SEMAC. It's tomorrow. No report from there.

PAD, Epipens and albuterol, glucometer, Narcan, no new to report.

I do have some notifications from Department of Health.

Ali Fattah from Brooklyn, New York, has been suspended for a period of -- deemed to be served concurrently with his patient restriction status with his employer and has been assessed a penalty of $2,000.00 for Part 800 violation.

Kenneth Relyea of Canastota, New York, his certificate has been revoked as of December 20th and assessed a $3,000.00

penalty for a Part 800 violation.

Those are the two notifications from the Department of Health this morning.

I do have a letter from Lee Burns to Mr. Klein, who is the Executive Director of Chevrah Hatzoloh. And it's regarding the request to waive the short backboard or equivalent capable of immobilizing the cervical spine of a seated patient. The short backboard still should have at least -- and she designates certain requirements for the device. And it's under the provision of Title 10 under Part 800. And they have to have it on each vehicle.

At the time the ambulance submits it's renewal application they want the letter reaffirming that they have updated this provision.

That's it from a State process.

I do have -- she put out this morning the meetings for the rest of 2017, look at them. We revised a couple because of conflicts or, I guess, mainly September. So please review and make sure the dates are

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okay. Our next meeting will be March 6th.

Any other things anybody want to bring up? Anything?

Are we bringing the meeting to adjournment? Anything?

Can I have a --

DR. VANROEKENS: Motion to adjourn.

DR. MURPHY: And second?

DR. PAPISH: Second.

DR. MURPHY: Thank you everybody for coming. I appreciate all your input.

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

Yvette Arnold