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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, October 1, 2018, at 9:35 a.m.

Yvette Arnold,

Court Reporter

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

DR. PAMELA MURPHY,
Committee Chair

DR. MARK PAPISH,
HVREMSCO Medical Director

DR. ARSHAD,
Evaluation Subcommittee Chair

WILLIAM HUGHES, EMT
HVREMSCO Executive Director

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DR. CRAIG VANROEKENS,
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DR. DENNIS MAO,
Director

ST. ANTHONY COMMUNITY HOSPITAL

DR. CRAIG VANROEKENS,
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MID HUDSON REGIONAL HOSPITAL OF WMC

DR. MARK PAPISH,
Director

ST. LUKE'S CORNWALL HOSPITAL

DR. FRANK FAZIO,
Physician Representative

VASSAR BROTHERS MEDICAL CENTER

DR. ARSHAD,
Physician Representative

ALSO PRESENT:

MICHAEL BENENATI
DAVID GRASS
DAVE JENSEN
ANDREW TARASOFF
RICHARD PARRISH
JOHN MAHONEY
DESIREE LEONE-STOLL
KIM LIPPES
BRIAN BATES
KEVIN GAGE
RICHARD ROBINSON
DAVID VIOLANTE

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DR. MURPHY: We will bring the meeting to order. You know, ACEP starts today so I'm sure we are not going to have a quorum. I wanted to go to San Diego, I'll tell you that. We did have a nice weekend, but I still would -- what a beautiful place on earth.

So first and foremost -- so we can do a roll call, but I've ticked off everybody on the chart who is here, so I think roll call there is five of us.

Oh, Craig, when did you sneak in? I didn't see you there. See? Maybe I should be doing a roll call.

MR. VIOLANTE: When you say ticked off, do you mean --

DR. MURPHY: No ticked -- don't say that. Don't say that.

So I would request an approval of the minutes from June 4th, seems like it was so long ago. Any accepted minutes would be approved, any deletion, corrections, or additions, just let me know. But can I have a motion to accept the minutes?

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DR. VANROEKENS: Motion.

MR. HUGHES: We can't vote.

DR. MURPHY: Oh, yeah, we don't have enough people --

DR. VANROEKENS: You can send it electronically.

DR. MURPHY: Yeah, and I'll ask everybody to sign off and do it that way. Yes, I wish I was in San Diego.

So the first thing under old business is BLS updates for last week we had SEMAC and we had to table all of our BLS updated protocols. It was a request from outside of our venue, mainly from some political avenues and from some outward pressure to the Department of Health so they are tabled for right now. I'll get more information on that as it arises, but kudos to Dr. Fullagar and Dr. Dailey for getting them into position. What we can do is I can send out copies to people, if you would like to review it and just look at it. We are trying to organize it so it's all in the same verbiage, same outline, same structure as the ALS protocols

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and it will be the first time ever they've been in sync in New York State so we are trying.

The process there was halted, it also involves that AEMT level of care and I will talk a little bit about that from SEMAC. Why don't I bring it up because it kind of goes right now -- I'll jump out of the order of the agenda.

So at SEMAC there was a few revisions that came down for specific areas. New York State brought in a few things -- sorry -- New York City brought in a few things from their ALS protocols and they eliminated etomidate from their formulary and replaced it with ketamine. They also brought forward transmucosal administration of Fentanyl. And there was a lot of conversation back and forth between Mr. Greenberg -- you know Ryan is the new replacement, the director for Lee -- and he has been going around the State visiting and touring, both a listening tour he calls it, at various sites. So he's bringing back all the information from each

area, which we will try to tackle one place at a time.

The biggest things coming up are people talking about the mental health issues. Pretty much looking at statewide quality measures and really to try to provide a better communication conduit from SEMAC in the State office. They are going to release a Bureau newsletter, which will have more information to go to each council and from each council and ton really hopefully expedite and facilitate that communication around the State.

The CC to paramedic program, the application process should be launched in January. Once it you complete the application it will take 12 months for the course. They had some CME changes that were program changes and the instructor component should be ready by the end of the year. He discussed all the new staff and new interns at the department and discussed, you know, things about how everything is trying to go electronic now, everything will be on the

on-line site, even the inspections, the back and forth documentation and there will be patient care reports on a single hub called the Hospital Hub and you will be able to obtain electronic PCRs there. So it will lessen the time frame of delay of when you drop off a patient and the PCRs available to the doc -- the providers in the ED. In the State of New York we have three million calls per year so it's a pretty voluminous number. And so it's a process, but it should work and they will get it through.

We ended SEMAC with an update from Nassau County on a complicated kind of process we initiated with an agency there and it's all been cleared up. We ended the meeting with kind of -- I don't know, don't look at it on the video, but it was kind of a crazy -- we had people come from Wadsworth, the two people in charge of the transfusion center applications now. And we got into a kind of a discussion about the laborious task it is to become a transfusion service and they felt they had made this a very

streamlined approach. It became pretty boisterous, let's put it that way. We will see what happens, that is the way it's left for right now. They are still trying to redo it, these two poor women were kind of assaulted by all of us on the SEMAC. But they unfortunately, you know, ended up inheriting this whole program so they are trying to make it better. We have to try to work with them. So there are right now in the State there is seven agencies that have approval to do such. But if you look at, you know, the number we have in the State it's like not even a pittance of the number.

So going forward I'll keep you updated on all of that. The BLS stuff I'll try and get out. I'll ask if I can release it -- because I figured we'd have it at least in format to show today, but they put it all on hold. So I'll request if we could just send it out so everybody can peak at it for now.

DR. ARSHAD: Can I piggy back on that?

DR. MURPHY: Yeah.

DR. ARSHAD: Just as folks start to

review the updated BLS protocols we will do something similar as we did for the ALS protocol roll out update a couple years out. So those items which are especially interesting, innovative, or represent a great topic for further education and improvement just highlight or star them because from the Hudson Valley we will be leading a similar sort of simulation based video CME to associate with the protocol update whenever that happens early next year. So those ideas that really capture your attention and say hey, we can dig in as a community and a region and upgrade the collective level of care, just star them or put in an asterisk and say, I can think of a great scenario to encapsulate this protocol update. And we will build a consensus and record those videos hopefully either Q4 this year or Q1 next year.

DR. MURPHY: I should have ended that with the whole transfusion thing. They had penalties in there for transporting with blood if you weren't part of the transfer

service transfusion service. So as a group SEMAC put forward a motion to the commissioner to say please do not hold harm to anybody who is transporting patients with transfusions, blood running because one, it's to save the patient and two, it's not something we try to do. But you know, they have to hold harmless until this is worked out exactly how they want it to be done and, you know, get more people on board. It's crazy to try and penalize anyone.

So we made a motion to go -- it has to go in letter format to the commissioner so that was done.

DR. PAPISH: What was New York City's rationale to pull etomidate?

DR. MURPHY: Yeah, it was pretty interesting. They feel that they -- the utilization of ketamine is more broad so they can use it cross many protocols. So they felt narrowing it down to just the one drug and trying to reduce the number out there so they switched and eliminated it and replaced it with ketamine, which I thought was

interesting.

DR. ARSHAD: Some additional insight, New York City typically does not have a depolarizing agent or paralytic as part of RSI process, rather they give larger doses of etomidate. So there is a potential for some harm there but first pass success can also be increasingly challenging without the implementation of a paralytic agent. And ketamine is a step wise upgrade to etomidate only for RSI process.

DR. PAPISH: It just seems there is some indications for etomidate that are great, there is the really short acting benefit of it without the side effects of large dose of ketamine --

DR. ARSHAD: Especially in the setting of decompensated heart failure with extreme hypertension such as CHF or intracranial bleeds where patients also have very high systolic and diastolic blood pressures ketamine may not be the ideal agent.

DR. PAPISH: I guess they have to waive that if they have a huge number of ambulances

and large stock they have to deal with so there is probably financial implications.

DR. MURPHY: And I think also the transport times because it's so proximate you know, they don't have really delayed pickups in transport. Although sometimes crossing the city can be, but I think definitely that why they -- that was the nidus behind it.

Mission lifeline STEMI protocol, I don't have anything.

MR. HUGHES: I don't have anything for it.

DR. MURPHY: Service upgrade. None for this meeting today.

Evaluation subcommittee report, Dr. Arshad?

DR. ARSHAD: So we have a case to present. We can present without the forms --

DR. MURPHY: Yes. I think that these are not things we, quote, unquote, vote on, more so discuss, have input and other pairs of eyes looking at it.

DR. ARSHAD: So we have one case to discuss. The concern was brought by one of

my colleagues at Vassar for a potential esophageal intubation. There was a municipal agency dispatched for an ALS call respiratory distress and that agency is nontransporting so simultaneously a private ALS provider was also dispatched.

I'm going to present the case at large, I think for the most part everyone involved attempted to do an exceptional job. There are some areas for improvement. Then broadly I would like to discuss within the region our approach to ensuring the high standards that are associated with this critical care procedure, endotracheal intubation and prehospital RSI.

So a woman, approximately 60 years of age. 9-1-1 is called for respiratory distress. The municipal agency is dispatched and ultimately starts caring for the patient. A private EMS agency ALS truck is also dispatched. And initially with the municipal crew they found the patient to be in respiratory distress, using accessory muscle use and speaking in short sentences with

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ongoing --

(The speaker cannot be heard.)

DR. ARSHAD: They started appropriate ALS intervention including a set of initial vital signs, adding supplemental to and then ultimately adding bag valve mask ventilation to help support the respiratory status and then ultimately prehospital C-PAP.

Now, simultaneously the private truck is also dispatched. It sort of coincided with a change at the county level where the specific GPS instructions were not transmitted to the truck and there was some delay -- which was certainly not their fault -- in arriving on scene. One of the field supervisors from the municipal agency was also standing in the side of the road and was able to grab their attention and they proceeded with their equipment to the patient's bedside.

They determined she needed to be transported quickly. She was moved to the truck and CPAP was continued.

Of note, there was copious vomit both preceding, during the active interventions

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and the patient had actually been discharged from the hospital for an aspiration pneumonia in the recent past.

With CPAP there was some marginal improvement in the patient's oxygen saturation, however, her mental status declined. The private ALS provider called our department for med control orders to proceed with RSI and was granted orders for etomidate and rocuronium and efficiently was able to pass the tube using the RSI meds.

Now, the complications are -- questions stem from this point forward. During that process there was copious copious vomitus in the airway. Aggressive interventions for suctioning were implemented. The paramedic who was performing the procedure noted the tube to pass through the cords, but nevertheless there was copious vomit within the tube itself. They were able to auscultate bilateral breath sounds, however, they were never able to obtain an end tidal Co2 reading, which was attributed to obstruction of the ET Co2 port on the

endotracheal tube itself. The patient's oxygenation covered between the high 70s and low 80s and they were received in the emergency department four minutes thereafter with no end tidal Co2 as well as the patient remaining hypoxic.

The ED physician was concerned that it could potentially be esophageal because there was no end tidal Co2 reading. That too was pulled and the patient was reintubated using glide scope or video laryngoscope.

Now, we had the opportunity to meet with everyone involved, as well as QA directors of both agencies. I firmly believe that everyone involved brought excellent ALS care to this case. And, in fact, I do believe the patient was endotracheally intubated.

The areas where I personally had concern and I would like to direct a discussion is if the tube is placed, even if copious vomit is obstructing the tube, without end tidal Co2 what is the appropriate course of action for the provider in that situation? Is it to pull the tube and to proceed with BVM since

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the tube cannot be 100 percent confirmed or is it to carry on and continue to ventilate through the mucked tube?

I'm not sure of the exact answer and I would like to bring that up for a discussion.

One room for improvement, however, was during that four minute interval, which is I'm sure, the blink of an eye when resuscitating a critical ill patient in the back of the truck, it would have been opportune to update the emergency department to let them know they believe the tube was in place, however, they did not have an active end tidal CO2 reading and to get further guidance from the medical control physician on how exactly to proceed.

So that is the brief presentation and I would like to open up the conversation for discussion, questions and any further inquiries.

DR. MURPHY: What was the total time they had the patient?

DR. ARSHAD: Total time -- it's complicated because the municipal agency was

first to arrive on scene and that was ALS provider as well. They did a fair bit of resuscitation on scene. There was a 15 minute or so delay of the private ALS provider arriving to the scene due to the county issue, which was unfortunate, but unavoidable and certainly not the fault of the provider. And then quickly upon the scene they decided that they needed to move, it was about a 12 minute transfer time to the hospital. And they did stop to obtain medical control orders, stopped the ambulance to intubate and give RSI medications and after the procedure it was a four minute transport to the hospital itself.

DR. MURPHY: I think requesting medical control when you find that you don't have a Co2 detector working and what to do in that scenario might have been a little more advantageous. But like you said, it's four minutes and a tough call because you are in the back and you're trying to do these things and trying to resuscitate them, but that might be the only recommendation.

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DR. ARSHAD: Some additional details, the case was reviewed with each individual agency, QA director, the paramedics, which I know personally very well in my estimation are excellent clinicians, and there was some remediation process with each individual agency. For the provider that performed the intubation, the RSI or MFI credentials were temporarily suspended pending this conversation at the evaluation subcommittee level. But nevertheless the provider was able to practice at ALS level and indeed has transported several critical patients with excellent performance and care in the subsequent future.

DR. PAPISH: They don't carry the color metric, the ones on the end of the tube?

DR. ARSHAD: I believe the New York State protocol is to have a numeric continuous end tidal wave --

DR. PAPISH: Right --

MR. BENENATI: Wave form actually.

DR. PAPISH: And we have pretty much gotten rid of those other ones? Because they

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are useful in this instance --

MR. VIOLANTE: We got rid of those a bunch of years ago because they would end up fouling very quickly if there is a bunch of vomit in the tube and the --

DR. ARSHAD: The total scene time for municipal agency was 40 minutes and total scene time and transport for the private agency was 25 minutes.

It's also of note, the patient was ultimately admitted to the ICU, but prior to going up to the unit had a CT scan of the brain which showed profound and anoxic brain injury and the family ultimately elected to withdraw care for that patient, they expired.

Any additional thoughts? Comments?

DR. MURPHY: How old was the patient? Sixty something?

DR. ARSHAD: 60s.

DR. MURPHY: I'm 60 -- due to be 61 soon.

DR. VANROEKENS: I would just say just the scene time seemed to be a little bit long. And, again, we are always, should we

stay and play, or scope and run? And, you know, even in the ED. I want to get rid of the sick patients as soon as I can, I want to stabilize, resuscitate and either admit or transfer. And I think EMS needs some of that same approach without being cavalier about what they are doing and I think it's a tough call. I'm sure these medics are very good medics, sounds like the process was adhered to in terms of review, but that might be my comment, to consider faster transports.

DR. ARSHAD: This was a challenging situation because the municipal agency is no longer allowed to transport. And at the same time there was an -- we could get into the details, but they are not as relevant -- our county in Dutchess had changed the dispatch protocol and information which is sent to private agency. And they had a really tough time ultimately finding the location which certainly contributed to the --

MR. JENSEN: It was additionally noted by both sets of providers that the original location of the patient was not idealistic to

perform the skill set that needed to be done.

MR. VIOLANTE: At the State we talked at the collaborative protocols of really using end tidal as the gold standard for everything, including any other kinds of airway devices, supraglottics, etc. So I think that's a related point to continue to use end tidal as gold standard for any kind of advanced airway and, you know, I think that should sort of be pursued a little more.

DR. ARSHAD: With full humility, I have performed endotracheal intubation in the emergency department and would have sworn that the tubes passed through the cord, but end tidal Co2 was undetectable. And in that situation my practice is to pull the cord -- rather pull the tube --

DR. MURPHY: Yeah, don't be pulling the cords just because you want it -- sorry.

DR. ARSHAD: I delivered my first born child September 1st so I was tugging on the cord a little bit -- nevertheless, end tidal Co2 of zero has to raise the red flags. And despite a four minute transport time you

either pull the tube, pursue bag valve mask ventilation, pursue a supraglottic airway, or even potentially attempt a reintubation in that scenario.

DR. MURPHY: Was she doing really poorly on the BiPAP?

DR. ARSHAD: Her mental status decreased significantly and she was continuing to vomit into the CPAP circuit. Again, the medical decision making up until that time point was really excellent and really it's the experience of the providers to say, hey, when things do not go as expected, what is my -- what is my backup?

DR. MURPHY: And to recognize she was not improving and actually declining.

DR. PAPISH: When she got to Vassar was the tube in the esophagus?

DR. ARSHAD: Nobody knows.

DR. WILSON: After the reintubation did things change quite a --

DR. ARSHAD: After the video laryngoscopic intubation and initiation of higher levels of PEEP to improve the

oxygenation the patient's oxygenation status did ultimately improve.

DR. MURPHY: So that could be another problem, you know, you don't have PEEP in the field like that and sometimes you need those higher pressures to especially aerate an aspirated lung.

DR. ARSHAD: I without a doubt agree, which boils down to again, I think a common theme in this case is even though it's only four minutes out reaching out to the med control physician for further guidance would likely have been the best possible scenario.

MR. TARASOFF: Really quickly, were there any attempts made prehospitally to kind of double check measures already in place, so were attempts for -- when the patient was intubated the first time to deep suction, try and clear the intubation tube and replace the wave form capnography sensor? Were any of those performed to kind of troubleshoot?

DR. ARSHAD: Aggressive suctioning, deep suction, as well as nasotracheal pharyngeal suctioning were attempted before, during and

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after the procedure. So, again, the acumen of the ALS providers in my opinion were high.

DR. MURPHY: An end tidal Co2 of zero not something you want to see.

DR. ARSHAD: So kind of wrapping up, I think, you know, knowing the provider I would feel comfortable having undergone remediation at the agency level, restricting the MFI restriction for this particular provider.

And I think we should perhaps discuss a TAG in regards to the standards within the Hudson Valley for agencies that do have MFI credentials and perhaps regularly reporting first pass success rates, the amount of education that is provided for these paramedics providing critical care interventions. I know personally I want to be in the lab and performing these high acuity low occurrence procedures --

(The speaker cannot be heard.)

DR. ARSHAD: -- and that's often times not the case in the prehospital sphere. And just ensuring that for those providers that we entrust with, you know, the advanced

airway and literally having somebody's lives in their hands, that we are providing them both regionally as well as the agency level the highest quality education to ensure that they are able to meet those standards.

DR. MURPHY: I think that each agency that does MFI has all those statistics and we could readily, you know, access them and the medical director from each agency should be looking at them. I think it's never a bad idea, you know, maybe what we should always ensure is at least once a year some of our CME we do incorporates that and maybe incorporates a sim lab of some nature, which would be open to everybody who does MFI and to -- you know, facilitate the process. I think you know airways are those tricky things and they can go bad quick. So I think there is never anything wrong with that no matter who the person or the hands-on the equipment is.

DR. ARSHAD: We have two additional cases we have not reviewed in full for a tube that was dislodged upon transfer from the EMS

cot to the ED structure, as well as another concern for esophageal intubation we have yet to review.

MR. VIOLANTE: Any thoughts about bougie, or PEEP, or endotracheal tubes?

DR. ARSHAD: I think that would be a great consideration. I would be highly motivated if in a TAG we were able to put together some additional recommendations for the Hudson Valley in addition to the State ALS protocols on best practice and mandatory equipment. I know a gum elastic bougie is something that in my estimation is mandatory when dealing with an advanced airway because it really does provide a highly inexpensive backup device that I think it behooves all providers tasked with the advanced airway to have within their arsenal. I think inexpensive devices like a PEEP valve, a positive end expiratory pressure valve, which can simply attache to your BVM and provides PEEP for patients who are otherwise difficult to oxygenate are a very low cost high yield intervention for specifically medics who are

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operating with that MFI credential.

DR. MURPHY: Do you think that that device works?

DR. ARSHAD: PEEP? Without a doubt.

DR. MURPHY: The little handheld thing --

DR. WILSON: Yeah, five or ten --

DR. ARSHAD: Yeah, and there is a fantastic video in the lab with sheep lungs and human lungs, things like that, that show your oxygenation and ventilation differences with and without PEEP. And really what it has to do with is at the molecular level the adhesion of the lung itself and elasticity and compliance. So without PEEP each subsequent ventilation requires greater mechanical effort to get the alveoli to that level of open distension. And what PEEP does is it mitigates that process and really optimizes the alveoli in situations such as CHF, COPD, pneumonia to maximize the oxygenation.

MR. VIOLANTE: Plus it's fun to say bougie.

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DR. PAPISH: Doesn't everybody have a bougie though? That's doing MFI? We don't mandate? It's an easy thing to mandate, it's so cheap everybody can be compliant. Do you not --

DR. MURPHY: I think every ED has bougies, but it's not prehospital. Dave, you guys ever use bougie?

MR. VIOLANTE: We just started --

DR. MURPHY: Yeah because it's not ubiquitous prehospital. We can -- we can do it as a local regional recommendation absolutely.

DR. ARSHAD: I think that will be our take away here, is let's discuss best -- so best practice with the state ALS protocol certainly advanced the spectrum of care. And I'm a huge advocate for educating our paramedics to the highest level possible and ensuring they have an A plus medical decision making task algorithm. I think at the Hudson Valley we can take this opportunity to elevate our care again and if we have some best practice guidance and standards,

including equipment such as inexpensive additions of the gum elastic bougie and PEEP as well as mandating that a certain part of the CME is advanced airway on quarterly basis in a simulation lab we can hone out or tease out the highest level of care.

DR. MURPHY: The little PEEP valves are like five bucks each?

DR. ARSHAD: Five bucks and bougie is five bucks also.

DR. MURPHY: Definitely. So you want to make a TAG?

DR. ARSHAD: Yes.

DR. MURPHY: So everybody interested and that would like to sit on that TAG and devise some of these ideas we bounced around this morning, please reach out to Arshad and let's move it forward. And maybe by the time we have the next meeting we could have some movement and then you will also have reviewed those other two cases so they kind of fit in line with exactly what we are talking about.

MR. BENENATI: Two questions. One should we just refer that to protocol and

have Dr. Arshad come and let them do that since that is part of their function anyway? And two is, what are the components of the evaluation subcommittee report if you got additional cases who sits on that committee these days?

DR. MURPHY: Me, Mark, Arshad and -- who is the other person?

MR. BENENATI: So is there prehospital representation --

DR. MURPHY: Yeah, there is supposed to be. And what you can do is for each evaluation committee you can invite individuals, you know, just to give yourself a rounded out representation for sure.

MR. BENENATI: So we should make sure we do that as part of the discussion phase.

DR. MURPHY: Yeah, he had sent it out to us electronically --

DR. ARSHAD: And, Jeff, of course is our QA/QI director.

DR. MURPHY: So we had all looked at it the only thing I would say, Michael, if we did protocol committee we would have to allow

other people interested to come on over.

MR. BENENATI: Well, they are certainly welcome.

DR. MURPHY: That's what I'm saying is to not limit it and, you know, open the invitation to anybody interested.

MR. BENENATI: Absolutely.

DR. MURPHY: And it does meld together nicely.

DR. ARSHAD: And certainly we would want representation from the private agencies, as well as as many MFI paramedics as possible to build consensus.

So as a last conclusion to this case I feel comfortable removing the restriction for MFI for this particular paramedic given the remediation, the skill set, the personal conversations I've had with this provider.

DR. PAPISH: He is never going to --

(The speaker cannot be heard.)

DR. MURPHY: Yeah, unfortunately our best education and remediation is when stuff happens, you know. And that's something you say to yourself, it will never happen to me

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again. We can all, I'm sure, think of one procedure at least in our lifetime that we had those events occur and, unfortunately, that's part of this job really.

Okay, thank you, Dr. Arshad, I appreciate it.

Dr. Berkowitz is not here, but what we are going to do is he said to me at SEMAC he is leaving Westchester -- I don't know if people know that.

DR. PAPISH: So the question is who will take-over the helicopter? It might be David, I'm not sure.

DR. MURPHY: So we just have to talk about that.

RTAC, was there a meeting in-between? I thought it was cancelled --

MR. HUGHES: No, there was --

DR. MURPHY: STAC was cancelled --

MR. HUGHES: Yeah. RTAC there was a meeting, most of the stuff really was uneventful. On the EMS side there was a lot of discussion about falls and preventions. And they have changed some of the formatted

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RTAC where we are now doing case studies and we are doing it either somebody brings in a case or Dr. Lombardi has a case he felt was important and a lot of it is transfers from other hospitals coming to them, what should be done, and what wasn't done, what was done, and what could be done better. So we spent a lot of time with that. We didn't spend too much time on anything on the EMS side so nothing really pertains.

MR. MAHONEY: They touched again on high flow oxygen and possible head trauma because I guess they went to the State and the State wasn't willing to change the protocols to address it. So they are trying to workout a way to see if we can get the EMS providers to administer the oxygen to any TBI patients.

MR. HUGHES: That's been an ongoing -- there was studies done, in fact, Dawn was here one day and made a presentation about the results of the study that they had made. And they are still looking for more oxygenation at the BLS and ALS level especially traumatic brain injury.

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There is one change that I did notice in BLS protocols, on the bottom of the AOA management it says in a situation where trauma is there you might want to use high flow oxygen. So I think there is a little bit moving in that direction.

DR. MURPHY: A little wiggle room.

MR. HUGHES: Yeah.

DR. MURPHY: Okay, quality improvement. Jeff?

MR. CRUTCHER: Nemesis 3.40, the bridge at the State is now active. We are in the process of moving over Image Trend clients first. We currently have four of those Image Trend clients on our regional bridge so it's a dual simultaneous push, data goes to our bridge and to the State simultaneously except if a document does not meet the validation criteria. For it to be accepted by the State the validation score has to be 97 or greater. If it's less, it gets kicked back to the provider, they fix it, resubmit it. In agencies that submit data in large batches that could be kind of a problem, which is why

it's encouraged to submit data as it comes in rather than hand in a large group. Image Trend has done a fair amount of work on this new bridge and they are adding a much better analytic tool to the report writer, which was intended to allow us to pullout better data so we can actually take a look and consider what KPIs are for each agency and help them establish some internal measures. And measured against not just our system, but the other systems that use the collaborative protocols and are in the collaborative group with us with EPCR and come up with pretty much a State standard for care and see how the measures work and where we can improve.

MR. HUGHES: Can I just --

DR. MURPHY: Yeah.

MR. HUGHES: Also on QA/QI at State level, every region has different QA/QI and different standards and stuff so one of the things Ryan Greenberg, who is the new director of the Bureau of EMS, requested that we get-together and report on our system of how it works on QA/QI and he wants to come

with a statewide system where everybody is really doing QA/QI the same way throughout each region. And the other thing that he wants to come up with is the KPI, key performance indicators, and have that where each agency could be evaluated against themselves and against their region and against the State at that level to try and improve the KPI of each agency. So I think we are going to see that fairly shortly.

The other thing that was mentioned that we haven't really talked about too much is the Hospital Hub.

Do you want to go into that, Jeff?

MR. CRUTCHER: You can, go ahead if you want.

MR. HUGHES: The EPCRs are going into what is known as the Hospital Hub, which will allow the hospitals to pull their EPCRs to them from all the agencies that are electronic. So with that in mind and doing that and being able to retrieve all of them from a central point the other push will be for all agencies to go to EPCR. So we see a

lot of push on that from the State although we haven't seen any money on that yet so we are not sure. So if you have influence over an agency and can convince them to go EPCR that would be a great asset to all of us in getting that data.

DR. PAPISH: I believe half of our agencies, right?

MR. HUGHES: About half are EPCR now.

DR. PAPISH: So the other half are still on paper.

DR. ARSHAD: Is there a cost associated with the hospital, or is it a benefit of being a hospital?

MR. HUGHES: I'm sure there is a cost. I think the cost is in the creation of the link between the Hospital Hub to the hospital system. I don't think that that is generic. I think that it has to be written software company. Some people said it was expensive and some people said it was inexpensive so I hadn't really looked into it myself so I don't know.

MR. JENSEN: Is that similar to the HDE

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program that vendors are currently offering?

MR. HUGHES: I think it's similar to that, but it depends what vendor you have that might get all of the input from different systems coming in, Hospital Hub does do all of the systems.

MR. JENSEN: The vendor programs allow outside agencies that are not on their platform to purchase a bridge to their program to be able to enter the stuff so --

MR. HUGHES: I don't know if they do that to all of the EPCR providers that are out there.

DR. MURPHY: He mentioned it, Ryan, and didn't talk anything about money, just FYI. I thought it was going to be like a freebie and that way you could connect on and utilize the information.

MR. HUGHES: No.

DR. MURPHY: Is that it, Jeff?

MR. CRUTCHER: That's it.

DR. MURPHY: So no PAD, or EpiPen, Albuterol, Narcan sites for this morning.

Protocol committee, Michael?

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MR. BENENATI: Well, first, congratulations to Dr. Murphy, who has been promoted at ORMC --

DR. MURPHY: Oh, I buried that memo.

MR. BENENATI: -- who is now the Vice-President of Emergency Medicine Observation Care and Physician Advisor. So congratulations.

DR. MURPHY: It just means I do more.

MR. BENENATI: So to add-on to what she has already reported, the goal is also to roll out the next version of the collaborative protocols with the new statewide protocol. The reason it's been delayed is because all of the BLS protocol is incorporated into the new collaborative and therefore, it will be a part of the app and the process once that happens. So the goal is to get a State approval in January and then roll it out sometime after that.

As a result of no action on the BLS or ALS protocol it was decided at the collaborative group that the previously approved AEMT protocols from May will be will

rolled out in a revision. So you will be seeing a revised collaborative protocols being distributed in the near future which incorporates only changes for the AEMT level and it will include a training component for those areas where there have been change from the AEMT protocol.

I believe Dave is going to speak about it, but nitrous oxide has been added to the -- for pediatric patients has been added to the collaborative protocols. They have removed the dilution requirements for amiodarone boluses in cardiac arrest. They have made ketorolac standing order for adults and changed the dose to 15 milligrams IV and 30 milligrams IM. They've also made a change which allows the first cardioversion dose for unstable irregular wide complex to be two hundred joules, this is now consistent with the dose of unstable irregular narrow complex tachycardia.

Then there was a lengthy discussion. It was initially added to AEMT level that we put McGill forceps in for obstructed airways.

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Then there was a discussion at the collaborative meeting that maybe it should not have been added as it is not currently in the New York State curriculum. So I believe at the end of the day it was not -- it did not stay in the protocols as a result of it not being in the New York State AEMT curriculum --

MR. VIOLANTE: National standard.

MR. BENENATI: National standard curriculum, which is used by New York State. That's correct, I'm sorry.

And then there is and needs to be future discussion about the governance of the collaborative group. There certainly may need to be some funding to support the administrative responsibilities for this group to maintain the document, to maintain the changes that are necessary with the apps, the printing, the clerical work involved. But that is to be discussed at a future meeting. And that is all I have.

DR. MURPHY: Yeah, we had thought about each region coming up with a figure that we

can standard it for every region just to work into their budget and relinquish to the collaborative group. Because we realized after this last revision in adding the BLS it was exhaustive for both Dr. Fullagar and then onto Dailey and to have some kind of support both from a prospective -- just even indexing all of those protocols was like crazy amount of time.

MR. HUGHES: Nassau County has also joined the collaborative protocols, so the only two regions that are left are New York City and Suffolk County. Everybody else in the State will be on the same ALS protocols.

DR. MURPHY: Which is pretty amazing. I think we will never get New York City because it's just too different for us. But I'm not sure what is the problem with Suffolk, but it's okay.

MR. HUGHES: They will come around.

DR. MURPHY: Eventually. So new business. Dave, you are up.

MR. VIOLANTE: All right, so hopefully this will work.

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So Dr. Arshad asked that I do a presentation on nitrous and the sort of Arlington experience with this.

Jeff, what do you want me to do with this?

MR. CRUTCHER: Just exit from it, that's fine.

MR. VIOLANTE: Okay, there we go. So do you want to turn the lights off so you can see better? That would be great.

So a little bit on nitrous oxide. A little history on it, pretty much it was first synthesized in the 1700s, it was used for a variety of reasons throughout time and in dentistry and surgery it was used as an anesthetic in 1844 --

DR. MURPHY: What were the recreation uses in 1799.

MR. VIOLANTE: They actually had what were called laughing gas parties in the bourgeoisie so that's what it was and sort of it's still used that way since in a variety of places.

But it has a wide use, as you can see,

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we are, of course, not looking to use it in rocket science in our industry, but it's there nonetheless.

In terms of safety, it can be pretty safe, but there are some limitations with it. And that is that it's minimally metabolized in humans so we have to be concerned about its use in confined spaces, which I'll go into. To that point there is a NIOSH recommended eight hour time weighted average of twenty-five parts per million.

So legal side, is that it's not really regulated by the DEA, but there are FDA requirements and different states sort of manage and handle nitrous use differently.

So what does it do? There is lot of stuff that it actually does. The predominant is that it works on the nicotinic acetylcholine channels, that's how it predominantly has its effect. I won't go too far into this unless anybody wants a patho presentation in which case I'll ask Dr. Arshad to issue CMEs this morning.

DR. MURPHY: A podcast.

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MR. VIOLANTE: Yeah. These are some of the old indications from our previous protocol. You'll see in terms of the new there is a pain management, how we pars out whens use is against contraindications, which I will show here next I think. And these are predominantly because nitrous oxide has a particular partial pressure and as it warms up that partial pressure then increases rather dramatically. So if you put this into a warm enclosed space it will expand and cause further damage, which is why you don't want to use it in a pneumothorax, intracranial issues, or things like emphysema, sinusitis, that kind of stuff. Because it will get into that space, potentially expand and cause paratrauma.

Effects. Predominantly we have reduction of pain sensitivity and some of the side effects also include some things we have seen experientially, but these are sort of full lists, but just I highlighted the ones we have been typically a part of.

And so in the Hudson Valley that's the

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1799 time frame there on the left -- we haven't done that. But on the right-hand side this is a typical Nitro NOX unit that is on the ambulance. And so there is a demand valve component right here that the person will use on their own, hold it in place and when they have had enough nitrous they will typically take it out of their mouth, drop the unit and that's when they have been dosed as it were and so each patient may have a different dosing so this is a way to regulate their inherent dosing. And the same holds true for pediatric patients as well, they just inhale it, when they can't hold it up anymore they've had enough.

We have used it in Arlington for a really long time so what is that, 28, almost 30 years we have used it, other groups have used it around the Hudson Valley. In 2014 there was discussion about not including it in the protocols so we did a retrospective pain management study against agencies in the Hudson Valley using it and came up that there is an actually statistically significant

decrease in pain associated with the use of nitrous oxide. We elicited the help of the Dutchess County Department of Health statisticians, we ended up do a T test and Wilcoxon signed rank test and came up with the same results except there is an average decrease of a little over four pain points on a one to ten scale. If anybody wants the tests and results, I'm happy to e-mail them out. That's a whole other presentation.

This is our current pain management protocol where it says nitrous oxide self-administered inhalation if equipped, so it's not a requirement. Again, the indications sort of go along with when would you use it for isolated extremity fractures, some kind of pain management otherwise, but not against any of the contraindications.

So we talked about some limitations is that there is an eight hour time weighted average of twenty-five parts per million of time exposed to this. The ADA where this is predominantly used in dentist's offices have an scavenger unit in place so that their

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staff is not exposed to this over time day after day after day since it is not metabolized, exerts its effects and leaves the body readily. Their suction requirements are greater than 45 liters per minute. The limitations in an ambulance are that the suction units are capable of just over 30 liters per minute were we would to use a scavenger system. So that's one potential limitation. Although we have windows and vents and all that kind of stuff that's all very very useful.

So we decided to do another safety study to determine what we needed to do in the back of an ambulance. We tested three types of ambulances, a type one, a type two, and type three. We concurrently tested the driver area and patient area. And then under three conditions of no airflow at all, airflow within the cabin, and airflow with use of scavenger and vent. And the results in the drivers area is that we exceed the time weighted average within about 60 seconds in the driver area when it was open with no

airflow. But then it dramatically decreased after closing the door between the compartments and opening the windows and turning the vents on. In the passenger -- which is obviously bad, you don't want the driver falling asleep going down the road with nitrous. In the patient area we have some similar results, but because it's used predominantly there an now the driver's area is sort of capped off with the vent on and windows open, per se, and a scavenger system in place, it is far below the eight hour time weighted average. But it took -- you know, you can see in the earlier cases with no airflow the numbers wasn't up pretty significantly.

So our -- one of the other questions that came up among the group when I asked who wanted to see what in a presentation were what do you do about diversion and provider safety? In terms of diversion we sort of follow a bit of what is happening in Vermont. We have a log of the nitrous tanks, they are weighed ahead of time, after use, and there

is a pretty specific group of people that are able to use them and so that's all documented in our electronic charting. Vermont says that you have to put the exhaust fan on and open the window at least an inch to have provider safety. And then they have logs and these tags to show how much was in the tank, when you used it, how much was used afterwards. There is really no other way this is just a liquid that --

(The speaker cannot be heard.)

MR. VIOLANTE: Here is our logs that we've used just to show how we are tracking this per patient, per use, per provider and per week.

And then we use a dual key system with our narcotics access that can be turned off and on remotely for access to narcotics and nitrous oxide as well so that's how we maintain safety.

So our recommendations are to use nitrous oxide for initial therapy and transitory pain management. Meaning if I have someone that you know is in a crumpled

mess at the bottom of the stairs and needs to be moved, maybe nitrous is the thing to do at moment while moving them and starting IV and getting them on some other pain management that might be appropriate. Or if we need to splint an extremity use nitrous, be they don't need to be on pain meds the whole time, we just use it right now, splint the extremity, they are okay, we stop the pain meds and they are fine with that. So it could be intermediary medications as well as is transitory pain management medication. When in the ambulance use the fan and environmental controls very much like the Vermont study there. And then discontinue use on arrival at the hospital. And then maintain patient care until the patient can remain unsupervised and/or care will be continued. Not that they're unsupervised in the hospital, but many times we'll deliver a patient to the room, get some information, we leave, the hospital staff is there, gets information and they leave and then the patient is in the room by themselves for a

short amount of time. What we are saying is stay with them until they can be in an unsupervised state on their own, not being under the influence of nitrous.

What I did not put in here is that it's extremely short acting so once they are off within several minutes they are very close back to their normal state and -- or I should say prenitrous state.

And so that's what I have for you guys. We have had great success with it. We have not had any provider issues, safety issues. We haven't had any turnover of care issues at the hospital. Typically, we'll take them off, have started something else, or it gives us some time for the physician to evaluate them and then decide a further course of action, which maybe better medications than what we provide prehospital anyway, or something different that is more appropriate for the patient. So that's what I have.

DR. MURPHY: Have you ever had any issues with diversion?

MR. VIOLANTE: No. We stopped having

balloons in the fire department so that there aren't any potential --

DR. MURPHY: Methodology for diversion.

DR. PAPISH: So your proposal is to expand this to pediatric population?

MR. VIOLANTE: It's already approved in the collaboratives that way. We would like to see it used in that method. In Shandaken especially over the winter months they see a tremendous amount of trauma because of --

DR. MURPHY: Ski slopes.

MR. VIOLANTE: -- ski slopes and whatnot, which affect kids and adults alike and they have used it very well in that setting.

DR. PAPISH: What is the lower age limit that they are putting in protocol, when the child is old enough to obey commands?

MR. VIOLANTE: Correct. They have to at least have the mental status to follow direction and commands to be able it utilize this kind of thing.

DR. PAPISH: Is that the verbiage that is there, do you know?

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MR. VIOLANTE: I'm not sure. I believe the verbiage is the person has to be able to follow commands, have an airway, not have any other contraindications because they are going to have to be able to follow what you say with putting it and on using it. If they can't, it's not for them.

DR. PAPISH: It sounds like a great idea. I think we should try and go forward with it. But I just have in the back of my mind a vision of a mother holding this thing onto a child's face and no one taking it off because the mom is keeping it on the child is --

MR. VIOLANTE: Yeah. No, the patient themselves would have to be able to self-administer.

DR. WILSON: What scavenger do you use?

MR. VIOLANTE: So there is number of them out there. We ended up using a modified scavenger for our environment because the dental ones came with this big whole unit. So we ended up using the tubing off of one and plugged it into our own suction machine

versus having their portable suction units attached to the device themselves. I don't recall the actual brand name that we have, but that is something --

DR. ARSHAD: So your best practice guidance is to close the window between the driver's cab and passenger cab?

MR. VIOLANTE: Yes.

DR. ARSHAD: Initiate the exhaust fan?

MR. VIOLANTE: Correct.

DR. ARSHAD: Have at least one window open one inch?

MR. VIOLANTE: At least --

DR. ARSHAD: At lease -- and then ultimately employ a scavenger?

MR. VIOLANTE: Yes. And, again, the time weighted average for a twenty minute drive in this scenario is far below NIOSH --

DR. ARSHAD: It was 18 --

MR. VIOLANTE: Right --

DR. ARSHAD: And what was NIOSH's upper limit they recommended?

MR. VIOLANTE: So it was 25 --

MR. BENENATI: So the protocol reads

nitrous oxide by self-administered inhalation if equipped.

DR. ARSHAD: And the pediatric protocol is the same?

MR. BENENATI: That is the pediatric pain management protocol.

DR. PAPISH: We don't have enough people to do a motion anyway.

DR. MURPHY: Yeah, we are one shy.

DR. PAPISH: So next meeting.

MR. BENENATI: Its going to be in the collaborative anyway so --

(Everyone is speaking at once.)

DR. MURPHY: And we can make recommendations if you want to add something in there specific.

MR. VIOLANTE: Yeah. I'm very happy to do any education for other agencies interested in doing this.

DR. VANROEKENS: David, I guess I would ask you draft something that meets the approval of Dr. Papish and Dr. Murphy that would advise other agencies about just those recommendations about safety, storage.

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MR. VIOLANTE: Okay.

DR. WILSON: And the contraindications.

MR. VIOLANTE: Yep.

DR. MAO: Maybe you can add in at the end after the patient is offloaded that the crew stay with the patient for a particular amount of time to be decided in the event the ED is tied up and help with the transfer process if the patient is sedated until they wake up. It will be safer for the patient while ED staff is getting involved with this particular patient.

MR. VIOLANTE: Yep.

DR. ARSHAD: It sounds like what everyone is saying as we formalize this process, if you are able to create an advisory or handout to share among different agencies, but also among different emergency departments to help educate them. Because for a lot of us this is new and I think you're presentation was exceptional and it will add a lot of value to our patients.

MR. VIOLANTE: I will note that this is at the AEMT level as well.

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DR. MURPHY: Thank you, David.

Do you mind turning the light back on?

DR. MAO: What about an MCI event and you have to transfer care to another team, it's not usually nitrous oxide. It's maybe something to think about within the protocol to allow MCI event how you would handle or don't handle.

MR. VIOLANTE: I don't know that we would use nitrous just because it's so provider patient specific where providers may have to deal with a number of patients. I would be a little cautious about not monitoring every patient.

DR. MURPHY: Unless we just don't open the windows or turn on the exhaust fan and throw them all in there --

MR. VIOLANTE: That's another option.

DR. PAPISH: Multi-dose --

DR. MURPHY: Multi-dose trials --

DR. ARSHAD: That's a good caution though, if there are multiple patients in the cabin it should not be used.

DR. MURPHY: Yeah. Thank you. So SEMAC

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report I kind of already did.

And Michael brought up the collaborative committee update.

So moving onto new forum or open forum.

I had sent to the office, you know, we constantly are talking about the drugs that are not available, that are out there that are going on a shortage list in this continuous process that occurs. So I'll pass it around and some of you may have seen it, five hospitals have banded together with some outside agencies to form a drug company. And what they are going to do is look at developing and synthesizing and putting out there all the drugs that we need that keep going on these shortage lists. And it's an alternative to this place where we are kind of held captive by the large drug companies and people not wanting to synthesize or do the real cheap drugs that have been around forever. So it's an interesting twist on the events so we can pass that around so people will see.

Also that came to the office was from

the Homeland Security and Department of Transportation along with Health and Human Services was a whole updated nerve agent handout in terms of the purpose, the background and symptoms and the methodology to using remedies for nerve agent exposures and the protocols. So it's something they wanted to put back out for everyone to have. So I can pass that around. If somebody wants copies, we will make it for you. Some of you might have seen it already.

Oh, I forgot -- before I ask for anybody else to bring something up -- can I read into the minutes the actions? I'm sorry, I should have done this sooner.

So first from the Department of Health we have a confirmation of appointment of Mr. Violante to the New York State SEMSCO. He will be representing us from the Hudson Valley REMSCO and your term will go through December of 2019. Thank you, David, and we appreciate that.

Now not so good ones --

MR. VIOLANTE: That wasn't the not so

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good one?

DR. MURPHY: That was the good one, that was the good one. So this is an action from Department of Health for Stanford Smith out of Brookhaven, New York. It's for violation of Part 800 with a suspension for one year and six months concurrent serving and a civil penalty of $4,000.00 towards that individual.

We have next Melvin Harrington out of Andes, New York -- is that how you say it? Andes, New York. It's a suspension for six months, effective September 17th, for an individual certificate for this gentleman with violations of Part 800 and civil penalty of 1,000. We did deliver this to the medical region -- medical director of our area because that falls into our region. We reached out to them principally.

Next, Bayside Community Ambulance Corp. out of Bayside, New York. As a result of investigation by the Department of Health the agency's certificate has been revoked so Bayside Community Ambulance Corp. and that was as of --

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DR. WILSON: That is a volunteer?

DR. MURPHY: Yeah -- as of May 29th.

And lastly Alejandro Cerano out of the Bronx, as a result of investigation the violation of Part 800 has revoked their ability individual New York State certification to perform. And this will be in effect as of May 21st, so since our last meeting.

Sorry, I should have put those announcements into the minutes earlier.

Okay, continuing open forum any new things anybody wants to bring up? Any announcements?

MR. VIOLANTE: I would really like to thank Kim Lippes for all of her time, who I'm apparently replacing -- but am not able to replace truly.

DR. MURPHY: Yeah, Kim, how long has it been, it's like --

MS. LIPPES: Too long.

DR. MURPHY: You don't want to fess up --

MS. LIPPES: I think it was eight years,

that's when you time-out and they kind of tell you you have to go.

DR. MURPHY: Thank you very much for all your time and it's a lot of time and effort and, you know, you guys spend these exhausting hours on committees and such and move things forward. So we appreciate it, Kim, and what you do with our office before that.

Anything else?

DR. ARSHAD: We have been working on developing an ambulance restocking protocol specific to our campuses just so that we can really optimize EMS turnaround times. And I know Dave has been doing a lot of investigation into what we are required to do and what is optimal to do. So I know he wanted to just discuss that further and see if it's potentially scaleable to any of the other hospitals in the region.

DR. MURPHY: Is this Dutchess?

DR. ARSHAD: It's Vassar specific and we shared amongst our sister hospitals, whoever wants to participate.

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MR. JENSEN: So the policy that has come forth is a safe harbor ruling by the Office of Inspector General for restocking of ambulances and it needs to be uniform in two methodologies. You have to publicly announce your program, so you have to post your program and it makes specific reference to following a current policy from a regional authority or the State protocols. And in researching for our program at Vassar the medical control plan for the Hudson Valley specifically says to replace one for one basis nonpharmaceutical medical supplies used in field units for those patients brought to that facility. I would like to see if there is a possibility to formalizing that to a policy that would also include pharmacological agents. REMO and Westchester both have similar programs that I can pass to Pam that require agencies -- facilities to either stock it or not to. And you have the choice under the State safe harbor ruling to either participate or not participate and also choose what level you are going to

participate to, but all that has to be in your public notice. And it's just in the research I found that the wording of the medical control plan is a little dated in reference to the restocking.

DR. MURPHY: Yeah, some places it's been a real hot button issue whether they want to or not so I'm --

MR. JENSEN: Depends how much interaction they have had with the Office of Inspector General. And our policy is that we restock to all EMS agencies medical supplies, pharmaceuticals and linen -- and linen is part of the program. Obviously, we do not restock controlled substances, that has to be part of the individual agency's plan. Out of our hospitals there is only two agencies that currently are restocked from our pharmacies as part of our plan.

DR. MURPHY: And that was something they worked out with their Part 800.

MR. JENSEN: The Part 800 portion isn't specific enough to tell what you are going to supply and what you can't supply. What I

would like to see is a policy from Hudson Valley that says that you would supply the nonpharmaceutical medical supplies, linen and pharmaceuticals, but it's a choice on the entity that has authority.

So Putnam could choose not to supply pharmaceuticals and medical supplies, but choose to do linen. Orange Regional could choose to supply all of it. It has to do with the public notice they put out, but in your medical control plan it doesn't specifically say pharmaceuticals.

DR. WILSON: I'm a little confused on what you are asking. Are you asking to mandate from Hudson Valley a decision one-way or another?

MR. JENSEN: Not to mandate it, just to have in the policy that if you choose to restock that it would be the policy as provided by REMO and Westchester's plan. So the individual facility has the right to decline, but as a region it's recommended that you do it to the medical control plan.

MR. PARRISH: In Ulster County we have a

restock form and we do follow the safe harbor and we restock everything that you mentioned, even the narcotics for two agencies because they are so small, but the rest, like Mobile Life, they purchase their own.

I'll gladly share that form with you. It's a two part form, one the agency keeps, the other goes with the patient's record.

MR. JENSEN: On the Westchester policy there is an example of the form they currently use and REMO uses a form as well. But you can document the information through the PCR as long as the hospital system is documenting the outflow of the material and the PCR can be utilized in that methodology.

MR. PARRISH: And that's what -- the form does show they got restocked and if for some reason we are short and they can come back and --

MR. JENSEN: So part of it is to try and reduce is the amount of paperwork that either agencies or hospitals are required to do. That's why we have choose not to do a form, we will do it through EPCR.

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DR. WILSON: The restocking?

MR. JENSEN: The restocking will be documented by the EPCRs.

MR. BENENATI: Just again, in the past the medical control plan goes through the protocol committee. We can look at it as a topic and bring forward a recommendation because we just reissued all of those administrative policies anyway. And if Dave has another one here for the nitrous that should just be a part of that process.

DR. MURPHY: Can I add these to his so he can have them as a reference?

MR. JENSEN: Sure.

DR. MURPHY: So let's do that and put to the next committee meeting and just another part of agenda we add on. And then we will report back here next meeting, but I imagine it's not an issue. I mean, it's just a thing where we need a modality for people that do it the uniform process and to have the public announcement about it.

Okay, any other information? All right --

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DR. ARSHAD: Another quick policy standpoint we can also relegate to the protocol committee is for medical control, I know most folks either call in and that is supported by current documentation, a lot of us in the region are using an app based method of call in now. So we just want to ensure compliance and see if we can work in some additional language to make sure we are compliant with the medical control process for those facilities that are using the app.

DR. MURPHY: Just including it in there --

DR. ARSHAD: Just adding --

DR. MURPHY: Just adding the verbiage --

DR. ARSHAD: -- as a potential and appropriate means of medical control contact.

DR. MURPHY: Yeah and as long as it's functional and capability.

Another thing for you, Michael.

MR. BENENATI: Yeah, I added it.

DR. MURPHY: Anything else?

All right, I'll have a motion to adjourn.

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DR. ARSHAD: Motion to adjourn.

DR. MURPHY: And second?

DR. WILSON: I'm second.

DR. MURPHY: Thank you all for coming.

(Time noted: 10:55 a.m.)

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

Yvette Arnold