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HUDSON VALLEY REGIONAL EMERGENCY

MEDICAL ADVISORY COMMITTEE

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MINUTES OF MEETING, held at the offices of Hudson Valley Regional EMS, 33 Airport Center Drive, New Windsor, New York, on Monday, November 19, 2018, at 9:38 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

OFFICE STAFF

JEFFREY CRUTCHER, QI Coordinator
KAREN DELAUNAY, Office Manager

GOOD SAMARITAN HOSPITAL

DR. DENNIS MAO,
Director

NYACK HOSPITAL

DR. GREENHUT,
Physician Representative

ORANGE REGIONAL MEDICAL CENTER

DR. ROANTREE,
Physician Representative

PUTNAM HOSPITAL CENTER

DR. BUTTERFASS,
Director

MID HUDSON REGIONAL HOSPITAL OF WMC

DR. MARK PAPISH,
Director

VASSAR BROTHERS MEDICAL CENTER

DR. ARSHAD,
Physician Representative

WESTCHESTER REMAC LIAISON

DR. ERIK LARSEN,
Physician Representative

ALSO PRESENT:

MICHAEL BENENATI
DAVID GRASS
JAMES JENSEN
ANDREW TARASOFF
RICHARD PARRISH
JOHN MAHONEY
KIM LIPPES
KEVIN GAGE
RICHARD ROBINSON
DAVID VIOLANTE
RYAN GREENBERG
ISRAEL KNOBLOCH

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DR. PAPISH: I guess we will get started, it will be an informational meeting.

Roll call.

Bon Secours?

Catskill Regional?

Good Sam?

DR. MAO: Yes, I'm here.

DR. PAPISH: Hudson Valley?

Health Alliance?

Northern Dutchess?

We should allow proxy voting, that would get our numbers -- Nyack Hospital?

DR. GREENHUT: Present.

DR. PAPISH: Orange?

DR. ROANTREE: Yes, present.

DR. PAPISH: Putnam?

DR. BUTTERFASS: Here.

DR. PAPISH: St. Anthony's?

Mid-Hudson?

St. Luke's?

Sharon?

Vassar?

DR. ARSHAD: Present.

DR. PAPISH: Westchester Medical Center?

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And REMAC liaison from Westchester?

DR. LARSEN: Present.

DR. PAPISH: All righty, review of the minutes. Everybody reviewed them prior to coming?

MR. HUGHES: I did and they looked good.

DR. PAPISH: Old business. BLS protocol update?

MR. BENENATI: So it is my understanding that the survey or solicitation of information has closed. There is currently a statewide BLS TAG committee meeting being scheduled. I don't think the dates have been picked yet, but they say that they are on course for -- hopefully for January. Lots of comments were received.

MR. PARRISH: Mike, don't they have a conference call scheduled for Wednesday afternoon?

MR. BENENATI: I don't know when I saw -- they do the poll, but I haven't seen the results of that --

MR. PARRISH: Yeah, sometimes Wednesday afternoon, it started like 12:00 o'clock and

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went to 6:00 o'clock for the option sometime the 21st.

DR. PAPISH: And the goal is to release them in January?

MR. BENENATI: For adoption at the State at the January meeting was the initial plan with roll out after that sometime.

DR. PAPISH: Cool. Service upgrades?

MR. CRUTCHER: We have several. Agencies that applying for BLS glucometry, Fairview Fire, Modena Fire and Alamo. For BLS 12 lead, Ramapo and Alamo. BLS CPAP, Ramapo and Alamo. And Alamo for Narcan and albuterol.

MR. HUGHES: Those have to be voted on so I don't know --

DR. PAPISH: Yeah, postpone for one month or until the next meeting.

(Dr. Murphy entered the meeting.)

(Discussion held off the record.)

DR. PAPISH: We were doing new service upgrades.

DR. MURPHY: So the new service upgrades, we've received preliminary stuff

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from one and a discussion from another to start the whole process. So the first is Village of New Square EMS and they would like to go to an ALS upgrade. That's the one you have most of the paperwork on, correct?

MR. HUGHES: Actually, we have asked Health Quest --

DR. MURPHY: Oh, they did, all right.

MR. HUGHES: -- and they are like 99 percent ready to go.

DR. MURPHY: So people are moving fast. So what we have to do, the next step is the office goes over and reviews all the information is there and that it's a complete packet. And we put together a TAG committee to review each one of the applications, all of its components and everything with them. And then we have a 30 day public opinion -- what is the word -- not public opinion --

MR. HUGHES: Comment period.

DR. MURPHY: Comment period -- thank you. So next step --

MR. HUGHES: We create the TAG --

DR. MURPHY: Yeah, if we could ask

people that are interested or involved, would like to be on part of the TAG, please let Bill know. And we don't need to take time now and do it -- it's going to be a record meeting.

DR. PAPISH: I'm not that efficient.

DR. MURPHY: You are efficient.

And the second one is the Vassar Brothers utilizing Alamo's certificate.

So do you want to talk a little bit about that?

MR. HUGHES: Okay, well, we can. Alamo -- well, Health Quest has submitted a request to have Alamo upgraded to ALS for interfacility transports in their area of operation. So their intent at this point according to the documentation is to put an ambulance that will be an ALS ambulance, be able to transport between facilities. And it will be an ALS ambulance that they are looking for and at this point it just says one ambulance. I don't know, you know, where we are going forward. Dr. Arshad is going to be the medical director. The certificate has

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been valid and -- you know, been kept valid over the years by submitting PCRs and it's going to be staffed by Northern Dutchess paramedics at this point. That's what we have in the paperwork.

DR. MURPHY: Okay, so --

MR. HUGHES: I don't know if you want to ask --

DR. ARSHAD: Yes, so very straightforward, this is part of our Mission Lifeline program just because we are the receiving facility for multiple critically ill and injured patients a single ambulance to go from Ellenville to Vassar Brothers Hospital to transport critically ill and injured patients in the disciplines of trauma, cardiac and stroke.

DR. MURPHY: Okay. So we will look forward to two TAGS, we could actually if we are tight we -- one TAG could do both.

MR. HUGHES: Sure.

DR. MURPHY: But either way -- and is someone here from Village of New Square that wants to make a few comments?

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MR. BREUER: David Breuer, I am EMS director for the Village EMS. And if any questions I'll be glad to answer.

DR. MURPHY: Great, thank you so much. So, everyone, if you could submit names for being part of the TAG, that would be very helpful and we'll move forward with both applications.

MR. HUGHES: We would like to have at least one REMAC physician on the TAG and several ALS services representatives.

DR. MURPHY: Yes. We have -- they have to have kind of a smattering of complexity of our group so that we represent all the aspects of our group. So we can definitely get people to be on that.

Okay, evaluation subcommittee report?

DR. ARSHAD: So we have no cases to review, but there is some additional commentary from the last meeting, if I may?

So while we were focused on the medical aspects of the case review there was some concerns from the county regarding the delay in dispatch. We had an opportunity to meet

with the county and we just wanted to reiterate after clarifying that there was not an issue in regards to the dispatch, specifically in regards to any change in the platform or upgrade related to that that affected this particular case and the response related to the case.

I had an opportunity to also discuss the case with the private ALS agency that had responded. And, again, they maintain there was an issue related to geocoding, but there was no significant change in regards to the EMD or dispatch information that was sent to the responding crews.

DR. MURPHY: Okay, great, thank you.

Come have a seat. Ryan, have a seat, please.

(Ryan Greenberg entered the meeting.)

MR. GREENBERG: Sorry for running late this morning --

DR. MURPHY: That's okay, you only just beat me. So I look good to you, but you are the only one in the room.

So introduce yourself so people can

understand who you are and -- it's okay, it's a good part of the meeting to do.

MR. GREENBERG: Good morning. My name is Ryan Greenberg. I am the new Director of Bureau of EMS and Trauma Systems, also referred to as the new Lee Burns, still about now, starting to be less of that. And just excited to be here and learn a little bit more about what is going on in this region. I apologize for running a little late, it took a little longer than I thought to get up in this region. So timing wise didn't count for some of the things I got stuck behind in the process.

DR. MURPHY: So Ryan's been going around to all -- throughout the State to just do information gathering, you know, talk to people, access each one of the regions, just to, you know, have some face-to-face time and gather some information. So, please, you know, if you would like to meet with Ryan and, you know, get kind of a gist -- do you have anything you would like to report from the department that you would like to

disseminate down in terms of information?

MR. GREENBERG: So I think the biggest one just kind of on that part of the listening tour is just trying to find out -- there is obviously many different parts of New York, each would have its own components to it and what are struggles and what is working well and what isn't. And in many cases some really good best practices so part of this listening tour has really been to find out what is working really well, what are you having trouble with, what can I help with -- not I -- we help with, and trying to work with some of that. And I would say some of the best stuff that has come out of this listening tour has actually just been sharing ideas, oh, you're having this problem? Hold on, they are having the same problem in Buffalo and here is how they solved it. Or they are having the same problem in Suffolk County and here is how they are solving it. So just kind of gathering some of that knowledge.

So please by all means, steal my ear,

either during the meeting or after the meeting and tell me what you are thinking and tell me what your wish list is. You know, if you got to change something in EMS what would it be and literally throw out anything. I've heard it all, but I want to hear it again because the more repetitive stuff that comes out the more likely that moves to the top of the line. Some people looked at me and said, well, this will never change or it will never happen. Well, if we don't talk about it or we don't try it, it is really never going to change so that's a big component of getting out there.

And I also just wanted to say thank you. Thank you for being here and putting the time in. I know our schedules and our lives are really busy and particularly on a REMAC side of things. So thank you for putting the time and effort into being here. And let me know how I can help make it better.

DR. MURPHY: Thanks, Ryan, and thanks for coming.

Helicopter committee report -- I assume

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is not going be to Berkowitz anymore?

DR. LARSEN: Not that I -- I do not know of any helicopter meeting that has gone on for quite a while and it won't be Berkowitz.

DR. MURPHY: Yeah, right. One --

DR. LARSEN: There is -- there is a doc who has been put in to fill Dr. Berkowitz's place. I have not met her --

DR. PAPISH: Is she -- I mean at Westchester but --

DR. LARSEN: At Westchester --

DR. PAPISH: But for the helicopter?

DR. LARSEN: In terms of helicopter I don't know who will head that up.

MR. HUGHES: I do have some information on the helicopter that I get from Hackensack when they come into our area and it's just kind of a small amount of information.

But they had a total request and this is for the month of September, they had a total request of 31 requests for the helicopter and they completed six missions out of that. And the way they break it down to me is by the requesting county. So they had fifteen

requests from Orange County, two from Dutchess, four from Sullivan, four from Rockland, and two from Ulster, and four from Putnam. They transported five adults and one pediatric, two of them were from the scene and four of them were interfacility.

DR. PAPISH: This is Hackensack, right, not --

MR. HUGHES: This is Hackensack --

DR. PAPISH: -- the overall data from --

(Everyone is speaking at once.)

MR. HUGHES: Right. I've been trying to get the same information from them and they are just not cooperating.

MR. GREENBERG: Who is your main helicopter?

MR. HUGHES: Air Methods.

MR. GREENBERG: And they just haven't been responsive?

MR. HUGHES: Yeah. Well, I've requested two or three times to do it and I talked to the guy at Hackensack because they are associated with them also and they were going to -- he was going to talk to them about how

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they do their format and sent it to us.

DR. MURPHY: It also maybe a problem with the transition of Dr. Berkowitz not being there anymore because we used to get regular reports and such so --

DR. PAPISH: And they are a pretty friendly bunch actually. So I think it's a just matter of getting the data, I don't think they will withhold it for any reason.

MR. BENENATI: Bill, do we need to be more active in doing something with this committee? I mean, certainly it sounds like all of a sudden there is a huge void with Dr. Berkowitz gone and maybe some opportunities. I know it's a Hudson Valley and Westchester collaborative effort, but do we maybe just need to take a little bit more of a lead so we can stay up on the information? I think that's important.

MR. HUGHES: Yeah. I think knowing when they are coming in and where the calls are very important.

MR. BENENATI: So do we have members of a helicopter committee in addition to Dr.

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Berkowitz at the regional level?

MR. HUGHES: Not at this point, no.

MR. BENENATI: So then maybe that's something we should look at reigniting.

DR. LARSEN: I mean, I am, but we haven't had any meetings --

MR. BENENATI: Yeah, I mean, you maybe -- maybe we should point that to Larsen as our Chairman from this region and get him some committee members --

(Everyone is speaking at once.)

DR. MURPHY: That's off the record.

(Discussion held off the record.)

MR. BENENATI: But maybe we need some ALS and other representation on the helicopter committee, I think that would be appropriate.

DR. MURPHY: All right, thank you.

RTAC, was there a meeting?

MR. HUGHES: No, there was no meeting since our last --

DR. LARSEN: Right, there has been no meeting. We had -- this body met --

MR. HUGHES: October.

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DR. LARSEN: Right.

DR. PAPISH: Do you know when the next one is roughly?

DR. LARSEN: It's not been scheduled I don't think.

MR. HUGHES: It should be right before -- right after the STAC meeting.

DR. MURPHY: It's right after SEMAC and STAC and then RTAC.

MR. HUGHES: Right.

DR. MURPHY: Okay, quality improvement report? Jeff?

MR. CRUTCHER: Progress continues on the transition to Nemesis 3.4. Had pretty good success bringing Image Trend agencies on board working on ESO agencies at this point. It's a time consuming process and we are constantly going over the validation rules to make sure everything works. And we have had some issues with validation scores and we've gone back to the rules to fix those, state rules as well as local rules we have built in.

Towards that we did look at intubation

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for the last almost two years with our ESO regional bridge. And found that overall there is a 69 percent first pass success rate with that. So it's not great, but it's not as bad as some of the other areas that I have looked at across the U.S., but there is still some work to be done with that. And of course that content include agencies that are not on ESO, but we do have a fair amount of ALS agencies including all but one of our RSI agencies. And RSI agencies that I've been able to look at actually have 100 percent on first attempt, so no issues with that.

IN Narcan, at this point in time we have distributed just over 1,550 doses of Narcan for agencies, which is about 500 more than we did last year at this time. The problem is not going away.

DR. MURPHY: No, it's only getting worse. Did anybody see the exposé on 60 Minutes last night? Boy, they ripped into the guys that make the Narcan know the talking one --

(Everyone is speaking at once.)

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MR. PARRISH: Kaleo --

DR. MURPHY: Yeah, there is a word for their system though, it's the Kaleo Pharmaceutical Company and they laid into them about the price gouging. It was very interesting. They interviewed an ED pediatrician who in Salt Lake City -- who would think Salt Lake City? But it's like a huge huge problem. And she and her staff go around and handout bags with a vial of Narcan and two syringes in them to anyone who wants it and they walk around all of the neighborhoods, of course the bad neighborhood. So they showed people you know resituating patients and what they did is do a live one so that the America public could see it. But the problem I had, is there was a cop doing nasal Narcan, which he had the woman handcuffed in the back of the seat of the car like this and he is through the window giving her Narcan and I'm like oh, my God, what a position --

MR. PARRISH: And that's all they did is pushed it and stood there and waited, didn't

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do any respiration.

DR. MURPHY: Initially you couldn't tell, she was handcuffed until she came around and.

SPEAKER: Maybe she was a prisoner first --

DR. MURPHY: No. She was in a blue fancy dress --

SPEAKER: Maybe she was a prisoner first.

DR. MURPHY: What am I going to do with you? So it's good that the America public are going see these things. And they interviewed a family, you know how they are trying to get Narcan into family members' hands, so they went through the whole process.

Okay, thanks, Jeff.

MR. GREENBERG: Can I touch on quality for a second?

DR. MURPHY: Sure.

MR. GREENBERG: If you watched SEMAC or SEMSCO last time they spoke briefly about it, we are working towards putting together some

statewide quality metrics currently five or six of them, so we are working on gathering what people are looking at today around the State. We will bring probably 15 to 20 of those to the State to the SEMAC and ask the SEMAC to -- we are asking them to pick five, if they can't decide on five and really want six, that's fine. But it's all coming from around the State and different things so if there is a particular performance metrics that you are watching here I would be happy to send anybody here a link through SurveyMonkey you can put it in there. We are seeing a lot of obviously duplicate things in some of the regions, but similar to what you turned in and said we are looking to see how we compare nationally. We are trying to get a look and say let's look at how are we doing statewide. With the goal also to be to allow people to look at agencies with similar sizes and similar regions and similar things. It eventually won't -- it won't say agency names or things like that, it will be more regionalized. But just again trying to get

towards those benchmarks and part of that initiative is coming from a lot of agencies turning when we asked them and when we are doing full service inspections and things like that, what are you looking for in quality? And they turn and say, well, we make sure we have signatures and that we have a full set of vitals. And they say, we'd like to look at more, but we are not sure what we're supposed to be looking at. So part of this initiative moving forward is to look at it from -- to help people look at hey, here some are things going on statewide and what physicians kind of say clinically this is what can really make a difference in patient outcomes and things like that --

DR. ARSHAD: What are some of the indicators other folks are looking at?

MR. GREENBERG: So I mean on the bigger side of things you're seeing a lot of strokes and STEMIs, you know, interestingly enough that first 12 lead is becoming more and more big one and so it's not just like you know oh, my God, the biggest intervention we can

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do, but it's you know a time of are we taking 20 minutes or are we taking 10:00 minutes? So you are seeing probably some of the biggest difference --

(The speaker cannot be heard.)

MR. GREENBERG: -- looking at intubation, looking at some other things that -- some of them are interesting, you know RMAs and who is staying home. The newest one being interestingly with Narcan. So if you administer Narcan and they turn to you and say, thank you very much, I don't want to go with you and the EMS provider is going, what do I do? You know so how is that being handled and things like that?

So it's just some of the parameters around what we plan to look at or what we'd like to look at is, it has to be able to be measured through an EPCR platform because we recognize that if we are looking at three million reports a year that the ability to do that manually is just not there. And so, you know, it has to be electronic, it has to be something we feel really has positive patient

outcomes and something that's being measured in more than one region to work on bringing that out.

DR. MURPHY: I hope the first one you talked about the signatures and form completed was a volunteer agency.

MR. GREENBERG: No, that's often across the Board, it truly is. And it's not out of anything else but sort of, I was told this has to be on there, or they are not sure what to look at. Or in same cases it's volunteer agency, because they turn and say well, I just got elected to this position last week.

DR. MURPHY: Yeah, that would make more sense to me than a paid agency.

DR. ARSHAD: If I might volunteer one as well? Again the question being is can we extract this information from EPCR for cardiac arrest if there is way to measure overall CCF or chest compression fraction. And we know in high performance CPR time on the chest and minimizing delays is what improves ultimately outcomes and intact neurological survival. So with the recent

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AHA guidelines they recommended a CCF greater than 80 percent and I think it's something if we can abstract from the data would be remarkable to setup very high standards for high performance.

MR. MAHONEY: Is it 80 or 60 percent? Was it 60 and they could possibly get to 80?

DR. ARSHAD: Yeah, the ultimate goal is 80 percent or greater.

MR. GREENBERG: I think the problem with that today is you know the equipment to have to measure what is going on. I think it's -- it's the right thing and what we should be doing from the educational point of view and hands on and getting people to think outside of the box. It was not until probably a year or two ago where my medical director turned to me and said, great, when you go to intubate on cardiac arrest, don't stop compressions. I've been doing this quite awhile and just the thought process was -- and to be honest, the newer paramedics were like, okay, no problem, because it's all they knew. To me, it's like okay, stop, so it's

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you know -- so the question would be how can we measure? If you have ways to look at it, we are happy to look at it.

DR. PAPISH: Can I ask a question? What percentage -- we are always faced with this regionally, but wondering if the rest of the State -- what percentage of agencies are fully EPCR?

MR. GREENBERG: Excellent question. So there is two ways you need to look at it statewide. So statewide 50 percent of our agencies are electronic --

DR. PAPISH: Good.

MR. GREENBERG: Yeah. However, statewide about 85 to 90 percent, depends on the year, of our charts are done electronically. So we do about 3.5 million requests for service a year and of that 3.5 million requests for service a year between 2.8 and 3 million come in electronically. Obviously, the biggest one comes from New York City.

So we actually looked in our office at a map -- and I'm happy to show anybody who

wants to look at the map after -- of the State and we put any agency that is covered -- or that is electronic in green, any agency that is not electronic or charting on paper in blue. And part of it is this initiative that we hope to roll out in the future of how do we turn the State green? From an environmental thing and also from a clinical point of view. The problem is is that you look at certain areas and they are either very very green or really big pockets of blue so it's tough, it is. There is no question that the data that we collect today gets a good picture of what is going on in New York, but it definitely doesn't represent all of New York, there are significant pockets with one of the biggest being Long Island. And that is tremendously still done on paper.

DR. PAPISH: I always liked to make fun of Long Island, we are far enough away.

DR. LARSEN: Just so we don't have any illusion about the green part, I mean what is happening at least in our area is that, okay,

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so folks are cranking out an electronic PCR in Westchester County, everyone is doing that. And then what they are doing is they are making a paper copy of it and they are faxing it to us, or they are sending it electronically to us and it's being faxed in our emergency department and then it's being photographed and put into the medical record, into the patient's hospital medical record. So there is at least one thing of paper being done there and probably two. So anyway, you know, whatever, it's just an aside. Because there is -- right now there is no way to have the electronic medical record or paper record go directly in electronically to the hospitals medical record --

(Everyone is speaking at once.)

MR. GREENBERG: So that's one of the things we are looking at.

MR. VIOLANTE: I've been working on that for six years probably, or more. And we are at that point and thank you for sending your letter out to hospitals because that was a huge piece in -- you know, the hospitals are

starting to sort of realize that the EMS community is an agent that they can share information with. And there is a number of platforms that do transmit stuff into the hospital platforms electronically. One is the HDE program, the ESO, that we have been working with the region to try and get into locally all the hospitals here. So that whenever a record gets done it goes electronically as a pdf into the actual patient's chart and then the information comes back out that the hospital allows the EMS providers to have so we can see even from QA perspective individually per call, hey, this back pain I brought in was actually not, it was something else, or the MI was actually -- or wasn't MI, those kinds of things. Plus it meets the guidelines for AHA, getting information back out, Mission Lifeline, trauma stuff, all those kinds of things.

So there is something out there, but we have been battling the legal side of the hospitals for a long time. So I think it's

start to finally come around a little bit, but that was a huge help in doing that, thank you.

MR. GREENBERG: And if anybody didn't get that letter it's posted on the website as well.

DR. MURPHY: It's out front for people to grab.

MR. JENSEN: If I may add to Dave's conversation? The HDE platform allows for the PCR to appear at the bedside in your platform as long as it's completed within the time that the patient is still there, that's the only fuzzy part of it. But you would be able to see the full chart from EMS while you are at the patient's bedside or in your corp in this platform.

MR. VIOLANTE: At the moment I believe ESO is the only platform that takes every other electronic version of PCR converts it to the HL7 code that the hospital uses for any of their variety of platforms.

MR. GREENBERG: So there is one other thing, if you haven't heard already, called

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Hospital Hub, which is a State program I'm working on, which started from the stroke initiative. And it's an electronic way of transferring charts to the hospital, the hospital would have a login to it. There has definitely been some speed bumps to it, but it's getting better, but trying to avoid the that faxing situation. But it's also dependant on crew finishing their call, then you can login, download it and upload it.

The ultimate goal hopefully of this letter that went out -- there are several goals to it -- but one of the initiatives of this goal -- of the letter going out there is also to help in regards to the --

(The speaker cannot be understood.)

MR. GREENBERG: -- and the different changes. There is a little bit of a road block right now, you have to have permission before -- literally signed off from every patient before that can move through the shining. And unless -- there are some exceptions to that. We are hoping that the quality metrics in this will allow for some

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the session to move, if that does there is --

(The speaker cannot be heard.)

MR. GREENBERG. -- more hospital systems to date. There is a legal restriction to it, not a -- well, there is a legal restriction to it. So yeah, we are working through that.

DR. ARSHAD: Ryan, if I can inquire further? Bill introduced the concept of Hospital Hub at our last meeting. And is that an initiative that's only available in certain regions? Because we tried to do some investigate into whether we would be eligible as a hospital to participate and I was told it's only certain regions, or is it a limited pilot?

MR. GREENBERG: So it's a pilot program right now in certain regions and depending how that goes depends how it's spread out. I'm happy to put you in touch with the person who is coordinating it in our office who can talk more about it.

DR. MURPHY: Besides the fact of just the exchange of information three things come to my mind. One is QA. How can we do decent

QA in any shape or form without having an electronic place where we can take all the information out of, so that's huge. And two, I know of two cases I reviewed from a medical legal standpoint where the EMS record was part of the challenge of this case. And they kept harping on this ED doc, did you review the EMS record while the patient was in the ED? And it was just this barrage of points, you know, that the plaintiff's attorney was going after this poor ED doc about.

So it's an issue both from a communication perspective, continuity of care and from a risk management perspective. It's a real medical legal issue.

DR. GREENHUT: Now, with that EPCR would it be pushed to both the Hospital Hub and to the hospital simultaneously or we are looking at you know basically developing a central database with Hospital Hub.

MR. GREENBERG: So Hospital Hub essentially can take electronic patient care reports from different multiple vendors, it pushes them to Hospital Hub and Hospital Hub

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is one direct to the hospital. So it sounds like similar to what you are doing with ESO in the region it's just in other regions. And if ESO is truly accepting any electronic charting system then --

DR. GREENHUT: Is Hospital Hub an independent state vendor, or is it part of --

MR. GREENBERG: It's part of Image Trend.

DR. GREENHUT: It's part of what?

MR. GREENBERG: It's part of Image Trend, which is our data depository --

(The speaker cannot be heard.)

DR. ARSHAD: One nuance split side from the medical director perspective is we have such incredible crews in the Hudson Valley that it also gives you an opportunity to acknowledge exemplary care. To say, hey, you did a fantastic job. Your commitment to excellence really made a difference in this patient's care and outcome. I think recognizing the hard work of our EMS professionals in the Hudson Valley is also one of our goals.

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DR. MURPHY: Okay, thanks. We have no pad EpiPen, Albuterol, glucometer, or Narcan programs to put through.

Protocol committee --

MR. HUGHES: We did that earlier but we didn't have a quorum --

DR. MURPHY: Okay, Mike?

MR. BENENATI: We have two -- the protocol committee me twice recently. We have two new protocol committee members, Andy Tarasoff from New Windsor and Israel Knobloch from Kiryas Joel. We welcome them to the committee to start assisting us in that process.

We still have three open items that we are going to continue to discuss. One is the use of bougies, which I don't know -- do you want to expand on this at this point? But generally it's well-received and certainly looking at moving forward with that, PEEP, and then the restocking agreements at a regional level. So we will continue to meet and obviously none of this stuff will happen overnight.

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So also maybe coming into discussion as of this morning might be suc and roc review and how it's used in the RSI protocol so we start looking at that as well, so we will continue to look at those.

And then the other thing Bill and I had been working with Ryan on is possibly getting him down here for a listening tour in the region. Certainly when we learned he was coming here today we just put it on hold to see if there was further need for him to come down or if he was going to get a good flavor of what some of the issues are. So maybe if we could have open forum following the regular agenda we can see if some of the topics have been addressed. And then we said we would discuss whether or not we wanted to open it up to other EMS folks and leaders and have him come down. One of the dates we are te natively looking at is Thursday, December 13th. So after we have more discussion with him today we can make that decision. And that's all I have.

DR. PAPISH: Do we want -- we don't have

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a quorum to vote -- but just about those items we were discussing, I mean, the issue was at previous meeting we talked about bougies and just, you know, whether to mandate equipment or make it, you know, available if we have it, you know, if stocked by the ambulance and I think that was the consensus of the meeting that we had.

If anybody has any thoughts or feelings?

DR. MURPHY: Well, I think bougies are pretty cheap --

DR. PAPISH: It's a dollar twenty.

DR. MURPHY: Yeah. But it's more so with the bougie is the educational piece to go with it. That's what we were talking more about it. It would be a great podcast and it would be probably a great video to, you know, utilize the bougies and people that see them. Because I think that's the only part with that -- and then the PEEP valve, right?

MR. BENENATI: Still on the bougies, there is a video on the bougies from the last training that we did at Laerdal from the protocol rollout. So that link would still

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be available on the regional website so if anybody wants to look at that, it's is there.

And I forget if you did that or Dr. Fullagar did that but--

DR. ARSHAD: Yeah, it's on YouTube. I think we encased the education within an actual clinical scenario and then we honed in on the actual application, quote, unquote, railroading the two best practices, when to employ that and things along those lines.

DR. MURPHY: And so I think just like with any kind of process improvement and things we are doing to introduce into the area we need to make sure people are comfortable with it and some format of are the medical directors going to, you know, review the process with their agencies and such. So something we have to look at, but I think there is no question the alternative methodology should be there along with what we described as the PEEP valve and such.

And restocking will never go away, just like medication shortages will never go away.

Okay, anything else from protocol or

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that's it?

MR. BENENATI: That's it.

DR. MURPHY: Okay, thank you for joining the committee guys.

New business. Active shooter -- is that for the Middletown High School?

MR. HUGHES: Yeah, that's you.

DR. MURPHY: I wasn't sure if that was my name, or is that SEMAC.

So there was an Orange County wide active shooter program we did at Middletown High School -- two weeks ago now, I think. It came off very well. I think one of the things with all these processes, you know, you learn what we need to do, you learn where we have problems, and you learn things that don't work. So Mobile Life and one other agency are trying to work together to form a tactical team. And so, I know, Arshad, you are very involved in all this stuff. So this was the first introduction of that process and such and so I thought it went really really well. The involvement was widespread, I couldn't believe how many people were

involved, but it went off quite well. It was something that, you know, we all say it's probably more when rather than if. So it was a great procedure and process improvement kind of issue for all of us. And the Orange County EMS office, you know, brought forward all of their equipment and the information was, you know, disseminated out. They had a nice debriefing afterwards and so -- especially for the Middletown High School staff, they were really involved. They were really quite helpful and really into it. So I think, you know, we have to realize that these people know it's a real entity and it's an issue we need to propagate forward.

SEMAC?

MR. VIOLANTE: Real quick? Mike and I were just talking over here, we've done something very similar in Dutchess County. We have six organizations working together to do just that in terms of that kind of group. And we were thinking that it's probably a good idea that at a regional level and then perhaps even at the State level we talk about

some centerization (sic) with that kind of idea when EMS implements how that sort of thing, there is lot of really good stuff that has came out from out west with their exposures for tactile EMS components and warm zone environment operations. I know at Arlington and LaGrange and Fairview we've implemented those strategies already so it's something good to look at regionally and then at a statewide level as well.

MS. LIPPES: Rockland County did something similar. What we did is we took some of the Homeland Security funds and purchased hemorrhage bags for the force. If they get people trained to Stop the Bleed instructor level, so they can go back out to community and issue the bags per agency --

(He speaker cannot be heard.)

MS. LIPPES: We also work with the police academy and every other week when they do the officers' training the second day they invite EMS people in to actively train with the response task form. Because they have a task force with EMS on it so that way it's

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training people in the agencies.

DR. MURPHY: Yeah, I noticed on the side of the Orange County -- you know, the big van they bring, it was from Homeland Security funds --

MS. LIPPES: There is a lot of funding out there and you just have to make sure you get the deliverables --

DR. MURPHY: Yeah, that's where that money came from --

MS. LIPPES: Just to go back for one second. When we were talking about the EPCR, what we did is the Health Department received a grant for $80,000.00 for opioid and one of the deliverables that were potentially involved in it were EMS being upgraded for EPCR. So we identified the last two agencies, the volunteer agencies that don't have EPCR and we were going to be bringing them up to speed and putting them on EPCR with that grant in addition to supplementing the ALS provider, a little bit, we can't cover the whole amount. So if you have that money floating around, I mean, it seems to be

hard to hit the targets of what it's required for, but EPCR is one of the very big targets on it.

DR. MURPHY: That's really good news.

MR. GREENBERG: So they recognize from an EPCR platform or from electric charting that EMS some of the fastest data -- fastest most accurate data comes in in relation to the opioid crisis in determining where problems are and different things like that. So actually by the end of this year there should be the release of the annual opioid report that comes out from the State. And if you get a chance to read it, it's actually quite interesting, I've seen a draft copy so far. But you'll see that a lot of different data points coming in come from EMS and EMS data that is collected so the that reason part of what is being brought up and why that's allowed to be used is that the more agencies that are electronic the better picture we have. And not only a better picture globally on an annual basis, but a better picture even on an emergent basis of

where the problems are and looking at it from that point of view.

DR. ARSHAD: To recognize some of the exemplary work that you guys have done, in my experience the programs that do the best are those that have strong multiagency training and response. So if there is an opportunity for us to spread some influence at the statewide level for all of public safety and that's, you know, the active training of fire, police and EMS to come together for these critical incidents and just to start to change the cultural norms, it's a hot zone and you stage a mile and a half away and wait for us to respond. And there is an opportunity depending on each individual municipality and locality that, you know, if we have strong cohesive multi-interagency operations, people know each other's names and faces, that when calamity strikes there is really an opportunity for us to save more lives working together and getting all those different agencies to work together, I think, you know, as it trickles down to the local

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level it's going to have a tremendous effect --

MR. BENENATI: Okay, and in fact, Ryan, I don't know are you familiar with the FBI's video "The Coming Storm."

MR. GREENBERG: I don't believe so.

MR. BENENATI: So I suggest that you reach out to your partners at the FBI, they have an outstanding video, which is "The Coming Storm" and it's exactly what Dr. Arshad is speaking about. In fact, when we first started look at rescue task force and responding to these incidents that was really the video that just convinced us that that's what we needed to do. You know, it's a simulated event in West Virginia, but also brought in experts from the LA airport shooting. And you have to see it. And we need to get it out to everybody, to fire, police and EMS because it's outstanding.

MR. GREENBERG: Okay, thank you.

DR. MURPHY: Is it from a perspective of a training video, or is it like just showing you what happened, what they found they

needed, or how did does it --

MR. BENENATI: It's a video that you walk away from saying that's the interagency and team work that we all need to do to respond to these drastic events. It's about coordination, it's about sharing resources, it's about nobody stepping on anybody, but a cooperative effort to accomplish the task which needs to be done. I mean, it's truly outstanding, I mean --

DR. MURPHY: So it shows the collaboration of all the different agencies --

MR. BENENATI: All disciplines --

DR. MURPHY: -- working together.

MR. BENENATI: Yep. I know when I spoke to the FBI agent in Washington D.C. when I initially called, he actually -- he was from -- he was a Kingston police officer, had gone on to the FBI and so was more than willing to do whatever we needed to do. And if you need additional contact just reach out, I'll get you his information.

DR. LARSEN: Along these lines, we did

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this in Westchester County about a month ago so it was all agency basically conference to pull us together. So hopefully I think we are a little better -- or a little further along than we were in the past.

DR. MURPHY: Yeah, definitely this event made us look at certain places where collaboration could be people stepping on toes, or not making sure we are providing all the resources across the spectrum, so it worked out really well and did it open a lot of eyes to things that we need.

Okay, SEMAC. So you are going to have to -- I'm going to have to apologize for being brain dead, but what I can tell you a little bit was, we discussed quite a bit about the BLS protocols and the revision. But I can't remember anything else, I'm like.

MR. BENENATI: I think we reported on that last time --

(Everyone is speaking at once.)

DR. MURPHY: What he did was talk about just the -- more so the verbiage and how he was changing things, but I couldn't think of

anything else.

MR. BENENATI: Yeah, I mean, we have a meeting coming up here within -- and you missed it at the beginning --

DR. MURPHY: January?

MR. BENENATI: No. We have a BLS protocol meeting statewide coming up probably next week sometime or maybe even this week --

MR. PARRISH: The 21st.

DR. MURPHY: Wednesday, the 21st.

MR. BENENATI: So hopefully we'll know more what the status of the BLS protocol is at that point.

MR. PARRISH: Yeah, they sent out a survey --

DR. MURPHY: SurveyMonkey, oh, yeah --

MR. PARRISH: -- and the options were any time from noon to 6:00 o'clock at night, a conference call.

MR. BENENATI: So hopefully we will know more.

DR. MURPHY: Okay, great.

So open forum. Just a little notification, I'm sure people in the area had

learned and its no secret, Orange Regional had to go on trauma diversion because we had to close our ORs for about a week, which as you can imagine for a hospital was pretty impressive, closed all elective surgeries. We found a problem with our major sterilization device and so the State -- we invited the State in, everybody came in and it was quite an event. But it was the only reason we had to trauma divert at that time because we just couldn't open an OR immediately for any kind of cases. Luckily, thank God, that's over.

Open forum. The other thing, Dr. Dailey, as you know, is the collaborative chair physician from the protocol committee. And what we are doing, he started a process and has one of the people from the REMO area going to go around and he's going to hookup with one of the gentlemen from Mobile Life and they are going to go around and educate people on the car seat and pediatric immobilization and make sure we are all on the same page about transporting pediatric

patients and that we are transporting them not in parents' laps and that we are using the commercial devices and the car seats that are available. So there is a nice educational process which they are going around agency to agency to discuss with people. That's all.

MR. GREENBERG: Not only the car seats, but putting the car seats in the correct place in the ambulance. That's a big issue that's come up is people are like, just put the car seat on the stretcher and we are good and a lot of car seats are not created necessarily to --

DR. MURPHY: And they have some really great devices, commercial devices that aren't very expensive, both for the infant, but all the way up through an adolescent of small stature, so it's pretty effective as an immobilization device for transport.

Any other comments? Open forum?

MR. HUGHES: Well, we need to confirm the meetings for next year, the dates.

DR. MURPHY: Okay, did everybody get a

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copy of it.

MR. HUGHES: No, it was a blank form.

DR. LARSEN: Bill, did you get our list from Westchester?

MR. HUGHES: Yes --

DR. LARSEN: So we don't conflict --

MR. HUGHES: -- and we don't conflict with any of them.

DR. LARSEN: Okay, great.

DR. MURPHY: We don't want to, absolutely.

If everybody wants to take these down these are what is the initial suggestions, Monday, January 28th; Monday, March 4th; Monday, June 3rd; Monday, September 9th; and Monday, November 4th.

You'll probably attach these to the minutes, right, Karen?

MS. DELAUNAY: No -- nope because last time you changed the dates.

DR. MURPHY: I know, I'm a pain in the you know what. As long as they don't conflict, we conflicted one with SEMAC and a big holiday. We were like all over the place

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last time. Let's all take a look and the more eyes that look at it the better off they will be.

MR. VIOLANTE: I have an open --

DR. MURPHY: Okay, let me just read in one -- so I have a Department of Health notification.

So we have for Juan Rosado out of Flushing, New York, he's suspended for three months effective October 30th. The suspension is stayed and he's placed on a probation of three years and assessed a civil penalty for violations of Part 800.

That's the only notice I have to read in.

Then you all will see that letter outside from Ryan Greenberg and the Department of Health to talk about that information and exchange of information with each of the hospitals. And I hope the everybody brings it forward, I know my executive team has already looked at it at Orange Regional.

And, lastly, the Department of Health

put out a policy statement, which is actually very helpful, regarding alternative medication formularies and some guidance when we have these prehospital drug shortages.

MR. HUGHES: The important part of it, the notice has been out for a while, but it has an expiration date buried in the alternative formulary and we have a note from the Bureau of EMS saying that it's not an expiration date on the policy, so that those are still added and valid drug formulary substitutions.

DR. MURPHY: And it just shows you kind of the procedures we should be going through from a regional level to an EMS agency level and just how we can share information and how to find a solution for these problems. Because, like I said before, they are not going away.

David?

MR. VIOLANTE: So we participate in the BLS epinephrine, it used be to the check and inject and now it's BLS epinephrine using vials for EMS providers --

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MR. GREENBERG: Syringe epinephrine.

MR. VIOLANTE: -- and we are running into an issue of availability of epinephrine in vial format where it ends up being very expensive. A box of 25 vials is $350.00 versus a box of ampules, epinephrine ampules is about 90. And so we had posed a question to the State about whether we could use the ampules over the vials and there was sort of a bit of head scratching going on.

And so I think at the State level the way that it's written is that it is for vial use and not necessarily ampule use in terms of the scope of practice for BLS providers for this particular program in and of itself. We wanted to pose a question as to whether we could put together a program for BLS providers to use the ampules and use the same program.

So I wanted to get people's thoughts here docs' thoughts, it's a perfect time since Ryan is here and the State guys are here. Maybe this ends up being something for protocol committee to discuss, but whether

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there ask a viability of EMTs under a particular program to use ampules over vials?

DR. MURPHY: And just meaning the --

(Indicating.)

MR. VIOLANTE: That is correct.

MR. BENENATI: The challenge that we have, as we discussed it, is that the State -- the State Bureau policy statement does use the word vial, so that's the challenge that we would need to overcome.

MR. GREENBERG: That and the training.

MR. BENENATI: That and the training right. The training we can handle --

MR. GREENBERG: -- are very specific to vial. So while you talk about this one, I'll also bring up the fact that Bound Tree has had a recall, if you haven't heard about this one already as well, on the syringe check and inject program. So just the syringe, the syringe that they used to issue had markings on it, fill to here for pediatric, fill to --

DR. MURPHY: Yeah, so what happened? Why did they recall it?

MR. GREENBERG: We do know not why the

recall occurred, but just the syringe was recalled. And they are sending out to every agency who purchased it from them essentially a one cc syringe with a regular marking, so a regular one cc syringe. So the Bureau is working on helping change some of that education. Ironically, that recall doesn't recall affect us that much because as far as we are concerned and i if you read the policy statement, our policy statement says you will use a one cc syringe along with a vial of epinephrine. So just recognize if you do get a phone call from your agency because they just got a recall notice from Bound Tree, that's what --

DR. MURPHY: So what do people think around the table about vial versus ampule?

DR. LARSEN: Why don't we just put a slash there ampule.

MR. VIOLANTE: So the training difference truly is if you are using an ampule you are going to use a filter needle and remove it and put on a regular IM syringe needle. So if you are just using the vial

you don't have to change those things out.

MR. GREENBERG: Does that add to the cost, using the filter needles significantly?

MR. VIOLANTE: Not significantly, no.

DR. MURPHY: It's probably more of a significance if somebody is going to snap it and got their finger, like somebody said.

MR. GREENBERG: Keep in mind low frequency, not necessarily high risk, but the risk associated with this so I think part of the Bureau's decision on using the vial is least amount of steps and least amount of complexity --

DR. MURPHY: Yeah, no needle change, that's huge.

MR. GREENBERG: You know, and also just in that how often is the provider actually doing the skill? Critical at the point they need it, but how often are they doing it and the risk associated with it.

DR. MURPHY: So I think that's a discussion for protocol committee, all right?

MR. VIOLANTE: All right, sure.

DR. MURPHY: Don't have enough on that

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agenda, add one more thing.

MR. VIOLANTE: I like to try and load the plate for Mike as much as I possibly can.

DR. MURPHY: I think that's more helpful to keep him out of trouble.

Open forum? Anyone else? David, did you have your hand up earlier? Mr. Green -- Grass, sorry.

MR. GRASS: I did not, but thank you.

DR. MURPHY: I thought you did maybe you were just scratching your head or something.

DR. LARSEN: I've got a few items. So is there any idea when the State guidelines around stroke destination and so on? Where are we going with that and is there any set dates?

MR. GREENBERG: There are no set dates at this time. They continue to have discussions, they are working on finalizing the regulations from the State level in designations and then from that make determinations at EMS point. So we are part of the communication and we are part of the conversations, but it's not been set.

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DR. LARSEN: So just for clarification I'm just not sure, does a hospital have to go through a certificate of need type process for this, or is basically all they need to do is meet the guidelines as whatever, set by one of the four agencies that is going to certify the stroke center? So is it simply they have to be certified by one of the agencies and they can go ahead and declare themselves whatever level they certified to?

MR. GREENBERG: I am not certain so I don't want to speak on that, but I would be happy to find out for you.

DR. LARSEN: Because I know there was a certificate of need thing, certainly with the PCI centers for heart, and looking over the New York State regulations I did not see that. It just -- it basically said, you know, you got to go through these steps, you got to meet these guidelines by the certifying organizations and you are good to go is what I assume, so I don't know.

MR. BENENATI: Erik, just for information, I went to one of the stroke

meetings in Albany, a day long meeting. And I think one of -- the discussion was the direction they were interested in going was selecting one of those accreditation agencies and then using that statewide. So then you would sign in with that accreditation, meet their accreditation requirements, and then use those designations there. So it was a very similar -- they were trying to tie it to the trauma process, but they were talking about just selecting one. Now, I don't know if that's changed, but like I said I went to a meeting in Albany, that's the way they were leaning anyway.

MR. GREENBERG: I would say I have not heard anything in regards to a CON process related to it, but I just haven't been looking at that because we wouldn't handle that portion of it, but I'm happy to look into it for you.

DR. LARSEN: Okay. So anyway just talking about -- so there's been a number of discussions sort of around this intubation thing. So there's been a fairly large study

that has come out that basically patients that have out of hospital cardiac arrests do worse if they get tubed. So -- and it's a fairly decent study, it's got its holes, but it's also a large number of patients. So one of the things that we should be probably look at in terms of the RSI is, does RSI improve that? Okay? Or is RSI just in that same ballpark? The one thing I don't know about that -- those studies and I didn't look carefully, is whether patients who are -- I mean, basically out of hospital cardiac arrest, I mean you are not going to use RSI so I don't assume that any of those protocols are in there, but I don't know. So basically it just sounds like people got tubed, then the sort of secondary or corollary is actually it seems that if you just use a, you know, a device like a king tube it was better.

And then along the same lines, epinephrine has also been totally called into question. And so I think that we need to start looking at those studies and hopefully

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those two things will be on New York State's big list of -- or short list of quality measures.

MR. GREENBERG: SurveyMonkey put in the request, I mean, that's the biggest thing. And we are happy to look -- like I said, we are just gathering what is going on and narrow it to down to about 15 to 20 things and pass to SEMAC so not only getting it on the list but turning to your local representative on SEMAC and, you know, pushing for that.

MR. BIGG: On intubation, I think it's about best practices too. I can say for our agency we have 100 percent success with intubation, we use bougies, we have a sim man, we constantly train our providers monthly on intubation and talking through things and --

(The speaker cannot be understood.)

MR. BIGG: We also have over 30 percent success with Ross discharges with our agencies also. We have about 5,000 calls a year so I do agree intubation is a problem,

but I think it's about the training of our providers and they don't do it necessarily on a call usually. No one is going to go find a sim man and practice intubation and go, that's a problem. I think things we have done is we sent our providers to different area courses, we train on it, we have the sim man, we change the airway around, we use bougies, we have valves. So I think it's about the best case practices other agencies might want to follow to have better success with intubation. Other than saying we're bad at it, let's not do it, why don't we fix our providers who aren't doing it enough or not training enough at those procedure.

MR. GREENBERG: Yeah the question is not about the success for intubations, it's the outcome on cardiac arrest patients and whether or not those patients should be intubated.

MR. BIGG: What -- the failure a lot of times we are showing was we are spending too much time tying into the -- and not doing compression, but if you can intubate and do

compressions as well you are going to have a better success so I think there is a lot of variables in that. We can study obviously why we are spending five, ten minutes intubating, not doing chest compression is probably important and why we are trying to tube before doing compression and stuff so I think that's a lot of variables. The providers need to be better trained on what to do, when to do it, when to call it, when to go to backup and that's up to medical directors to review with their agencies.

But we have been successful with, Andrew and everybody else, looking at every single intubation and saying listen, you missed the first time, you are not going to get it the second time, we are going to --

MR. GREENBERG: Well, are you looking a the success of intubation or the success for cardiac arrest --

MR. BIGG: Both. Intubation first pass, but again obviously setup procedures, checklists, making sure we are doing things correctly and talking through it. Luckily we

have two paramedics on a cardiac arrest where it makes things easier for us. But as far as training the providers if they are only doing it a couple times a year on a cardiac arrest and maybe having difficult airway class brought into the region and letting providers go to these things and learn better practices.

MR. VIOLANTE: So you are offering to put together an airway class?

MR. BIGG: Sure. We have the sim man and stuff to do it. I'd love to -- let anyone else that wants to use our sim man we got to for free from Laerdal if you want to use it, try it. I mean, our sim man has broken teeth, that's good it's on there not on patients. But I think that's really important just training your providers, not going to CME just talking about how to intubate and actually intubating and make sure.

MR. GREENBERG: I think I'm familiar with the class he is talking about, difficult airway class, so two days for the providers

and it really does have a very good balance of practical time as well as classroom time and there are similar classes to it, I just happen to know that one.

MR. JENSEN: I know that other regions host skills nights where they have their providers come in and meet minimums for the regional level. REMO requires pediatric intubation, pediatric sticks, as well as adult intubations, using the bougie as well. So that maybe something the protocol committee can look at developing here --

MR. BENENATI: For the training and ed.

MR. JENSEN: Sorry, I was just trying to put more things on the --

MR. VIOLANTE: Yeah, and Mike just phoned Dave in. I think Mike we will reach out and if you guys can do some stuff for the region, that would be great.

DR. LARSEN: So, okay, one other coming from Westchester. There has been some push in Westchester for people doing RSI with just one paramedic. So I mean I just want to hear people's feeling about that?

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DR. PAPISH: Is there data that they do worse?

DR. LARSEN: What?

DR. PAPISH: Is there any data that single paramedics have lower success rate with RSI?

DR. LARSEN: Unfortunately, I don't think it's been looked at in any kind of scientific way so I don't know. It's just everyone in -- everyone is doing it -- in the Hudson Valley is doing it with two medics, right?

DR. MURPHY: The whole collaborative --

MR. BENENATI: It's written in the collaborative.

DR. MURPHY: Yeah. And the second paramedic doesn't have to be RSI credentialed, they can just be -- how did we word it?

MR. BENENATI: Trained.

DR. MURPHY: So they can help facilitate the process. I think this was a big stumbling process in the very being that had no wiggle room. I think from around the

collaborative audience we -- it was pretty standard that everybody wanted the two paramedic model and that was not something to stray from. Because originally we didn't have it here in the Hudson Valley so we had to change it to be in line with that process. So that was -- I'm not sure how much they are going to want to wiggle on that one.

DR. PAPISH: Was there some discussion about switching from succinylcholine to roc as the first line? Because I heard something --

DR. LARSEN: Well, there was, but it was because of shortages.

DR. PAPISH: But there was no clinical reason for it?

DR. LARSEN: No, there was no clinical reason. It was because of shortages and we felt since it was in the formulary we would just substitute.

DR. MURPHY: Any other comments?

MR. GREENBERG: Two quick things. But when you first spoke about the pediatric car seats and things like that, we are -- we just

recently got a grant in regards to pediatric emergency care coordinators for agencies, this is through our EMS For Children program. And essentially they are working on coming up with some best practices for agencies to comply with, that they would have one person designated as the pediatric coordinator and then they had a series of best practices that they would work to do within their agency. Fairly realistic things like make sure you do one pediatric training a year, know how you are going to transport a patient and have a policy on it not -- by the way, on mom's lap doesn't count, a couple things. So that's going on right now as a statewide project to come up with what those best practices or guidelines would be. And then within the region if you could encourage your agencies to have a pediatric coordinator that would be great. If you want more information on that I can put you in touch with Martha who oversees our EMS For Children program.

We also just got a grant for leadership training. So we are working over the next

year to develop some EMS leadership training. I've heard a lot of on the listening tour, you know, a lack of opportunities for training, you need to get elected or move up, or given the gold badge or whatever it is and they say, good luck, we'll let you know when you mess up. But we don't necessarily do a great job of providing that initial training. So we got a grant on that one and we will be working on some initial training for new leaders as they come up.

And the third one is we have another opioid grant that is coming up that we are working on, we'll hopefully have more information on it in the near future. But that would be additional training for providers on how best to handle some of the situations and how to handle some of the newer situations we are dealing with now such as we administered Narcan and then they turn and say -- like our diabetics that we have had for years -- they turn and say, thank you, I don't want to go to the hospital. How then do you handle that so there is a

hopefully positive patient outcome, both at that immediate time and long-term.

DR. MURPHY: We are kind of struggling with that question right now in the collaborative protocols and what is the best way to handle it because it's a real issue.

And I can say I had to write a paper -- not a paper -- a judgment summary for the hospital for a case of a family that was suing on a kid that, you know, they reversed -- he refused to be seen and that night died of an overdose. It was thrown out, but it was just something to think about that these issues are there. And it's dilemma. You know, what do you do? And it's a thing of -- you know, that's something I don't know who has the answer to, of what is the right thing to do. But I think if somebody has capacity you have to allow them to make a decision for themselves as long as you feel they have the capacity to make that decision.

MR. GREENBERG: I think part of, you know, kind of where this is coming from

becoming more of issue, obviously the opioid crisis is becoming more of issue which is raising a concern, but in addition to that as we have more and more BLS providers who are, here is the administration, give exactly this amount, and it's much more likely to wake up them to a point where they are fully alert, oriented and sometimes aggravated to the point where they really don't want to go anywhere it's become more of that issue. You know at the point it was just at the ALS level it was about how do I bring them to wake, but breathing, and where I don't have to maintain respirations so we didn't see that dynamic. The other thing that is happening is --

DR. MURPHY: Not to the point where they can talk to us.

MR. GREENBERG: And I think, you know, that changed the dynamic also is it's now whether the point of the administration and waking up is happening in the home, where before it was maybe they were out on the stretcher or someplace maybe if they were

sitting on the fence it was a little bit easier for them to say, all right, I'll for a ride. And so part of this training and part of this is to actually helping that, you know, not only on the decision side, but follow-up and talk on different levels.

DR. MURPHY: Okay, anything else?

MR. MAHONEY: Has there been any updates on the transport of patients with blood and blood products?

DR. MURPHY: It's still, you know, a process that you can apply for, go through the application process. The one problem I think has been really the hospital side of it and the comfort level and that integration of the two. Because they have to really -- that blood bank and laboratory division chief, whoever it is, whether it be a pathologist or whatever, they have to sign onto that process so it's not changed since the last discussion we had.

MR. JENSEN: The thing I found is then legal gets involved because it's an agreement. So that's where I'm stuck, I have

three agencies that are either in the process or have accreditation already, but the process is mired down because legal wants to go through the agreements and make sure everything matches up to them.

DR. MURPHY: It's not easy by any means.

MR. GREENBERG: And on that front just so you understand, the process is much better than what it used to be. It has not changed and the regulations have not changed, so there was some miscommunication, I think from people watching the SEMAC. They voted on a moratorium, that was them voting on wording to a letter they were writing to the commissioner. It was not them voting that there was a moratorium, so there was some confusion on that one. Nothing has changed in regards to the regulations at this time at state level, but I do encourage everyone if they feel there is an issue or within their hospital and stuff like that to address it with the appropriate parties so that it is not forgotten about -- although I think it that would be hard for it to be forgotten

about. We have about 24 agencies out of 1,200 that are currently ATS certified. And there no flight programs today that are ATS certified so just to give you a snapshot of what that looks like. It's something we are working with, but those regulations are not under us, they are under a separate section so we are trying to work within that.

DR. MURPHY: And the two women that came to the SEMAC will never come back.

MR. GREENBERG: They were actually very positive when they walked out, we did speak to them afterwards. And if you don't know what we are talking about just go watch five minutes of the SEMAC it will be very clear --

DR. MURPHY: They are coming with flack jackets next time.

MR. GREENBERG: Right, I don't know if they will come back or --

(Everyone is speaking at once.)

MR. GREENBERG: Right, exactly, it might be a situation where they will only answer questions submitted prior to arrival, but they have been -- you know, again, the two

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woman who took over, just recently took over, they really are trying to change it. They understand there are some challenges to it. And we are -- the biggest problem actually isn't Wadsworth, the biggest problem is the ambulance service has to have an agreement with every hospital that they would be doing blood transfers for. So and I go back to flight for a second, you look at flight, they could possibly turn and say I need 170 agreements. And so even if they wanted to do that, what are the challenges of that? And so right now they say you got to do that -- but that is some of the challenges. You think submitting something to the State can take some time, submit something to hospital legal department, they work at the same pace.

DR. MURPHY: Yes, that's where the conversation stemmed from.

Okay, anything else?

MR. BENENATI: So we are at two hours, I don't know that we will get an opportunity to do some other listening tour stuff with Ryan at this point. So we will probably continue

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with getting you down here on the 13th of December. So Bill and I will get an invitation out to everybody so that you can come and have an opportunity to interact with Ryan and address some of the other issues.

DR. MURPHY: And if people want to still hangout I think he's here so it's not an issue.

MR. GREENBERG: Exactly, I'm happy to stick around for anybody that wants to --

DR. MURPHY: Can I have a motion to adjourn?

DR. BUTTERFASS: Motion to adjourn.

DR. MURPHY: And second?

DR. GREENHUT: Second.

DR. MURPHY: Thank you, everybody.

(Time noted: 10:58 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