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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 6, 2017, at 9:30 a.m.

Yvette Arnold,

Court Reporter

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DR. ARSHAD,
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DR. BERKOWITZ,
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WILLIAM HUGHES, EMT
HVREMSCO Executive Director
JEFFREY CRUTCHER,
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DR. VAN ROEKENS,
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CATSKILL REGIONAL MEDICAL CENTER

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Physician Representative

GOOD SAMARITAN HOSPITAL

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DR. ARSHAD,
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WESTCHESTER MEDICAL CENTER

DR. BERKOWITZ,
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WESTCHESTER REMAC LIAISON

DR. ERIK LARSEN,
Physician Representative

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

ANDY LAMARCA
NICHOLAS GARDINIER
MICHAEL BIGG
DAVID GRASS
MATTHEW GOODNOW
MATT NOLAN
ERNIE STONICK
RICHARD ROBINSON
BJ LEIDNER
ISRAEL KNOBLOCH
DAVE VIOLANTE
KEVIN GAGE

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DR. PAPISH: On the record. So Pam had a conflict that she was unable to miss unfortunately and hopefully we will get one more person -- or two more people, but it doesn't seem like that is going to happen.

So going over old business, 2017 medical control provider update?

MR. HUGHES: Yeah. We have a list of all the hospitals that are complete. And we just have Health Alliance of Hudson Valley is still missing one provider, Northern Dutchess is still missing one medical control provider, Putnam Hospital has four medical control providers missing, Sharon Hospital has three, St. Luke's has one and Vassar still has 21.

DR. PAPISH: Um --

DR. ARSHAD: Good luck --

DR. PAPISH: -- I was going to say we were doing pretty good.

Did he take his test?

Okay, so you can bring that back to everybody. It's really easy now. I mean, there is -- they modified it so.

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DR. RABRICH: Yeah, soon it will be three questions --

DR. PAPISH: -- can't make it any shorter. It would be nice if we got that done.

With regards to the Narcan update?

MR. CRUTCHER: No changes.

MR. HUGHES: The only -- one change that is coming down is the new Narcan spray that is coming out. It's four -- point four --

DR. PAPISH: Four milligrams.

MR. HUGHES: -- four milligram instead of the two milligrams we have been distributing. And it's a single use, you just hit the plunger and it is live and active you get your Narcan.

DR. PAPISH: It really sprays, it's like a squirt.

MR. HUGHES: It's under pressure somewhere in there. And so there is no assembly, there is nothing, otherwise everything is pretty much the same except the dosage is twice what the other dosage was.

MR. NOLAN: And the cost is three

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times --

MR. HUGHES: Could be.

DR. PAPISH: I don't know if you saw, it was in the news recently about how it's generic but the price has more than tripled in the last year for Narcan.

MR. VIOLANTE: Being made by the EpiPen people.

DR. PAPISH: It's pretty amazing. This is -- really the epidemic, it's -- I don't know you guys at your hospitals, but I've never seen more overdoses like -- and deaths in August we had more cardiac arrests from narcotic overdoses at my hospital than we had medical arrests, which is sad.

Hospital diversion. So we put out the letter --

DR. RABRICH: There is a bunch of typos in this.

DR. PAPISH: Yes, it hasn't been -- did you get the spell check?

MR. HUGHES: I did, I went through it --

DR. RABRICH: So line 3, 9-1-1 receiving hospitals contributes to -- should be

increased turnaround times for ambulances, not decreased, right? Elective ambulance diversion would increase turnaround time.

ERs should be EDs.

And nit picky, but PSAPs, plurality, that last S should be a lower case.

DR. PAPISH: That is why we hand it out before we send it out.

MR. LAMARCA: In the procedure section, number one, I don't know if it reads right. General hospital diversions will be absolved throughout the Hudson Valley Region.

DR. RABRICH: Eliminated --

DR. PAPISH: Eliminated, yeah --

MR. LAMARCA: Obviously --

DR. RABRICH: We are forgiving you for diversion -- but we are not.

And then number 2 under procedures it talks about diversion for specialty, but there should be something in there too regarding a facility issue, like a fire, loss of power to the facility, those would be the only other reason to divert.

DR. PAPISH: Further comments? Anybody

object to it?

Berkowitz just came so we have -- we just need one more.

DR. BERKOWITZ: I feel honored.

DR. PAPISH: Any objections? Okay, so we will make those modifications, send it out.

Psychiatric patients and dispositions this is on the agenda, but I don't remember what the discussion was at the last meeting. Anybody? Pam put it on.

DR. RABRICH: I don't think there was a discussion.

MR. HUGHES: She said that she had no update on it when I talked to her.

DR. PAPISH: Yeah, and I don't think there was any plans -- does this ring a bell with anybody?

MR. LAMARCA: A while ago we had that discussion about medical clearance and units were going into, you know, 939s instead of to the closest ERs.

DR. RABRICH: That was a couple meetings ago.

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MR. LAMARCA: Yeah, so I'm not really sure.

DR. PAPISH: I mean, I would love it if we just all went to the local emergency department. As one of the psychiatric receiving hospitals we are constantly overflowing --

DR. RABRICH: I second that.

DR. PAPISH: -- we had 17 holds when I left this morning.

But if there is no further discussion I don't think there is anything new on the issue.

BLS protocols update?

MR. VIOLANTE: So those are still at the State level undergoing review and discussion. They are looking to have them approved in the January time frame and it totally depends on how much discussion and sort of nit picky points people get through, but that's where it is at the moment --

DR. RABRICH: Nothing was ready for the last SEMAC SEMSCO so they are hoping for January.

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MR. HUGHES: They moved them to the trauma group and the EMS for Children's group to make sure they looked at them and were acceptable.

DR. PAPISH: Service upgrade? You want to wait?

MR. HUGHES: Yeah, we can't do anything --

DR. PAPISH: Until we get one more person -- okay, if Dr. Chung comes like he says.

Evaluation subcommittee report?

DR. ARSHAD: No cases to review.

DR. PAPISH: John, helicopter report?

DR. BERKOWITZ: Nothing going on right now.

DR. RABRICH: They are not flying.

DR. PAPISH: Not even flying.

DR. BERKOWITZ: Exactly.

DR. PAPISH: RTAC?

DR. BERKOWITZ: We had RTAC last Friday, they talked about a couple of things. The status -- you know, the status of all the hospitals. There is -- Dr. Winchell, I

believe has a role on STAC, is doing a project to look at the -- kind of the layout of where the trauma centers are. So I know that they were -- I mean, that's going on. I think they have representation from all the regions now. The representation from the Hudson Valley would be -- I think it was Dr. Lombardo, Kathy Arnow and John Winski from Orange and someone from Vassar I believe.

DR. LARSEN: Right.

DR. BERKOWITZ: Who was it?

DR. LARSEN: That new woman who is the coordinator.

DR. BERKOWITZ: Yeah, I forgot the name. There is a decent amount of representation from the region. Actually I don't think Kathy is on it, I think it is Kim who is on it, Kim Truando because she covers pediatrics. So we have adult, pediatrics and we have a couple of level twos, so representation on that project if anything ever comes out of it.

They are doing -- they have to do PI projects and the PI project they are doing is

the use of oxygen in prehospital care. So we discussed -- I think Eric discussed this last time, but just to remind folks they are putting a big emphasis on this and they definitely have cases of patients who are -- meet the trauma criteria or physiologic criteria for CDC who don't have oxygen on. There is definitely the misconception that oxygen is bad in trauma patients. I don't think that exists and the evidence says it's good in the trauma patient so they will be more for that, more education as well.

There is also discussion about the appropriate notification and report tool to be used prehospital so they were talking about the MIST tool, which is really geared to trauma. So I think that what I'm going to do is get some documentation together and just share it with everyone and we can look and see if we think it's a good thing. It would be good if we standardized how we communicate with EMS, what we expect from them. I think that -- you know how we do probably remains to be seen.

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DR. PAPISH: The historical issue in EMS notifications to the hospital it like waxes and wanes. It's come up recently in our region, we have been talking about it. And on the one hand I feel like we always try and come up with a standardized format, which is good and -- but at the end of the day I think it's a matter of provider experience largely.

DR. RABRICH: So I agree with you. I don't think it's so much a problem of what to say, it's recognizing mechanism and knowing when to call for that notification. I find that particularly at the BLS level it's often lack of understanding of MOI and that I need to call ahead for this and go to the trauma center more so than the information actually contained in the report. I agree it would be good to stander ize the report but I think we have a larger issue than that and I think an appropriate number of --

DR. BERKOWITZ: I agree. And I also think it's important to differentiate the notification that we get and the report that we get, which in some circles that's

interchanged and they are different. I mean, the notification is shorter, has to be more concise and it's almost harder to get an SBAR type of format for that because, you know, that inherently leads to -- potentially leaves the most important thing at the end of the SBAR, meaning if you are using MIST and you get cut off at the S -- because we all know people get cut off -- and part of the treatment was you intubate the patient or gave them epi, you don't know that happened.

DR. RABRICH: MIST is good for that hand off --

(Everyone is speaking at once.)

DR. PAPISH: I think we have a quorum.

DR. RABRICH: I think we just have to be specific --

DR. BERKOWITZ: Maybe when we discuss it maybe we can talk about -- since we can talk about some sort of process for the notification part so that people don't think that whatever we use, MIST, MIBT3 -- but it might be good to look at different too so whatever we decide upon we say this is what

we think people should do for notification and this what we think they should do for report.

DR. ARSHAD: I think both are active issues. And we have been discussing it at the Dutchess County level in terms of prehospital activation for critically ill patients, whether that be PCI, trauma, stroke, et cetera, but also the bedside report element of it. And in regards to the education regarding mechanism of injury, within our new standardized ALS protocols actually is a reference to the 2011 CDC field activation trauma guidelines, which delineates the trauma activation criteria quite specifically. And I read that 20 page document and one sheet handout, which is included in the app for protocols, I think it's an excellent means of education, is comprehensive and we should potentially use it to continue the educational process and standardize, or do a best practice sort of model for radio reports for critically ill patients.

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MR. VIOLANTE: This is a great point. I'm glad you are bringing it up because this gives the region the opportunity to standardize something region wide that we are would seeing right now in every hospital the cardiac center wants one report, trauma center wants another report, different trauma center wants different a trauma report and this is a fantastic way to get not only the quick report, the 30 second I don't have time, but you need to know what is coming and the bedside, which is a really important facet for that side of it.

We are doing something in Dutchess. We have a conference this coming weekend that we are going to elicit some feedback from providers because it's a good idea that people that have been around for a while and new providers still do the same thing for every hospital wherever they go. If the region comes up with a standard this is what we follow and if you need a little bit more, great, if you don't have time, there are some really important components, that's fantastic

too. But to come up with both of those is a great idea from the provider side as well and going to every hospital.

DR. BERKOWITZ: This is definitely something within our capacity, in our control so I think that we can do this and do this for both regions at the same time, probably make the trauma surgeons happy, which is sometimes a difficult feat. It's not a bad thing to do so I think that we should work on this because, you know, this doesn't have to go to the State -- no offense.

DR. PAPISH: So our game plan, you are going to send out --

DR. BERKOWITZ: I'll send stuff on MIST, maybe we should have a TAG meeting to discuss what are people thoughts --

MR. VIOLANTE: We can send you the work we have done at the county level in Dutchess. We talked to a number of hospitals, staff and personnel and some providers too and we can send it out to you guys. We had -- our county trauma meeting that we did some work on it so we will send it out. And what

feedback we get from the conference could be helpful to incorporate a lot of ideas and thoughts from providers as well as physicians send it to the physician group and --

DR. PAPISH: Why don't we create a little TAG? And it can community via e-mail, there is enough people --

DR. BERKOWITZ: And it crosses our region, you know, this region and Dutchess county as a subpart of that. So probably a good thing for a TAG, we'd probably knock it out --

DR. RABRICH: I think this is more a training issue than a protocol issue, training, maybe a GOP kind of thing.

DR. PAPISH: Yeah, but once we come upon a -- the exact framework that we want to delineate and roll out then, you know, the roll out is -- we can have a few educational --

DR. BERKOWITZ: Yeah, some nice videos or something.

MR. LAMARCA: I think it's more likely to be accepted if you do have it come out of

here, obviously, with the standpoint -- if not, you still get a hospital telling you I would rather have the report some other way.

DR. LARSEN: It should come out I think a minimal from Westchester too.

DR. BERKOWITZ: 100 percent.

DR. ARSHAD: I think --

DR. LARSEN: But one thing we have to be careful about is if we have too many sort of reporting mechanisms for different types of things, it's hard for -- you know, you are in the field and a lot of stuff is happening in the back of the ambulance or in that house and you are trying to push packaging up the patient and trying to remember what points do I include in this. So it's got to be something that, you know, if -- you know if you are in the cardiac world, or you are in the trauma world there has to be a lot of common elements there so that you are spitting out, you know, over that radio what needs to get to the bottom. Because a lot of it is also where your destination is going to be and there maybe destination decisions and

that is important for your medical control folks. So we can't have too many ideal reporting systems, that's all.

DR. RABRICH: No, it should be one --

DR. PAPISH: It should be one and there is some obvious details within each type of patient. You know, if you are bringing in a stoke you need the last known well time and you don't need that for trauma --

MR. VIOLANTE: The other side to this too is there are a few other things out there that are possibilities. There are a few apps that you can use from the scene to do it and this and that and those are okay, but I think still we have to go with a standard at the moment. So if I'm going to Westchester then I use the app, if going to Hudson then I don't use the app and if I'm going to Vassar --

DR. PAPISH: It's quite possible in the a year no one is going to be calling anything --

DR. RABRICH: We are using the app and it's working very well.

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DR. PAPISH: So we will create a TAG, have a little e-mail exchange, come up with something that sounds good and everybody agrees upon.

MR. HUGHES: Who will be on it?

MR. VIOLANTE: I'll be on it.

DR. ARSHAD: I will.

DR. PAPISH: So Dave, John Berkowitz, Arshad, myself, Matt Nolan.

DR. BERKOWITZ: It would be nice to get like a BLS or VAC, someone like at that level would be really because they are the ones that have to use it. And I think to -- just point we want something people can use --

DR. RABRICH: Right.

MR. VIOLANTE: We'll get a lot of feedback from the conference so we can get information from those personnel and --

DR. BERKOWITZ: And maybe you can help canvas those.

MR. HUGHES: We can also pick -- we can probably pick out a BLS agency that would participate.

DR. BERKOWITZ: Thank you.

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DR. PAPISH: Moving along, we now have a quorum so service upgrade?

MR. CRUTCHER: We have two applications for the use of BLS CPAP, Marbletown and Upper Delaware.

DR. PAPISH: Can we have a vote?

MR. HUGHES: Yep.

DR. PAPISH: We will vote for Marbletown and Upper Delaware for CPAP.

Everybody?

ALL: Aye.

(Everyone is speaking at once.)

DR. PAPISH: Unanimous. Excellent.

Anything else?

MR. CRUTCHER: Nope.

DR. PAPISH: Upgrade are done. QI?

MR. CRUTCHER: The only thing we have still moving forward is awaiting New York State release of the Elite Bridge. They are telling us the first quarter, they still haven't said which year, but we are presuming 2018.

DR. PAPISH: Okay. Any insight on that from the State?

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MR. ROBINSON: No.

DR. PAPISH: Protocol committee?

MR. VIOLANTE: We did meet as protocol committee, the only thing that came out was work on the policy manual, which, Jeff, I think you can --

MR. CRUTCHER: Yep.

MR. HUGHES: Part of the collaborative protocols we took some of the nongeneric stuff that related to us and it was what we had in policy anyway and created a policy and procedures manual. What you had outside was the index for that and what it allows us to do, instead of making it available the way we had it, which was a very large document it was about 150 pages, maybe 160 pages on our website, what we have done is break it down into three segments, one is credentialing policies, the second one is clinical procedures and policies and the third is the shadow program. Each one of those now have numbers associated so we can move and change those policy in and out if there is any change rather than redoing the entire manual

and renumbering everything. It was just an onerous thing trying to keep track of it so this will make it much easier for us. The policy is available, nothing has changed -- there was one thing we added, right, RSI?

MR. CRUTCHER: That was just a change back to --

MR. HUGHES: Okay, that's right, it was a change back from MFI to RSI because of collaborative protocols. Otherwise everything here is in our current policy, it's just reformatted to make it a little bit easier to find and a little easier to work with.

Do we need a vote on that?

MR. VIOLANTE: I don't think so.

MR. HUGHES: I don't think so, it's just matter of information.

DR. PAPISH: Okay, new business?

DR. LARSEN: So I made this announcement at the RTAC and I'll make it here. You know, because of the sort of natural disaster things that we have had going on in the country for the last three months, basically

since the hurricane season and fire season, there has been the need to activate the National Disaster Medical System and a lot of the DMAT teams around the country. HHS, the Health and Human Services, under which NDMS falls -- the Natural Disaster Medical System falls under, has been on a hiring freeze for a number of years now. So that people who are interested in applying to become members of DMAT teams or working with NDMS, that has sort of been closed. And it was just announced -- actually while I was in Puerto Rico, and we had basically ramped up every team available in America and culled people from many different teams to put together complete DMAT teams down there, it was announced that they are going to open up hiring. So it seems that they are sort of experimenting with this and they are going to go for a two year sort of -- I don't know if it's really probationary position --

DR. RABRICH: Temporary position --

DR. LARSEN: So anyway, people may want to distribute that out there. It's certainly

for a broad variety of people in the health care system, doctors, nurses, advanced practice providers. It seems like they are going back to opening up to EMTs and paramedics because for a while they weren't taking EMTs. So it seems like it's going across the board so if people have interest in that, you have to go onto USA Jobs and you should also go to the HHS site, subdivision ASPR, the assistant secretary for preparedness and response, subdivision MDS. And you will find -- this should appear, it was promised by Ron Miller, the head of NDMS, this would come up and be on the site within two weeks and this was approximately a week ago. Anyway, you have to get your application into USA Jobs and I certainly would encourage people to do that. If you have any interest in participating in the National Disaster Medical System and the DMAT teams --

DR. RABRICH: You should also e-mail, you know the team commander and the team you want to be on, e-mail them as well. They can

assist with this. They were talking about the possibility of emergency hiring outside of USA Jobs for that temporary position, which you would have to reapply to USA Jobs after that two year period. They also raise the GS grade for paramedics from seven to nine.

DR. LARSEN: The government service rate --

DR. RABRICH: The government pay rate, they increased it for several positions, paramedics being one of them, but all the teams are in need of personnel.

DR. PAPISH: They were having trouble getting people to come.

DR. LARSEN: Well, the system has been in trouble for, you know, the last few years and, of course, it's a funding thing. And so, you know, they realized that they need this, this is the Federal asset when States are overwhelmed and ask for Federal assistance, or if the President of the United States declares a Federal emergency, this is the asset. NDMS goes out and the DMAT teams

are their functional arm so they are trying to staff them up.

The old experience was you went out with your entire team from -- you know, it was like New York 2, New York 4, those teams would go out as a whole unit, otherwise they didn't get dispatched. Now what is happening is that, you know, my team, which was down there, NY 2, we had probably 20 people from NY 2 and the rest were filled in by people from other units, which has its good and bad aspects. I'm not sure of a correct answer on this thing, but it's nice when you sort of know your team members and you work together and there is some kind of unity there. But disasters are disasters and New York 2 hadn't been out since I had been out with them in Hurricane Ike, so as a team. And there is not much money for training, there hasn't been much money for training so people haven't trained. It's, you know, a big deal --

DR. RABRICH: It should approve with the new ASPR, the assistant secretary for

preparedness and response, he comes from a response background and has committed -- he's actually been in the field and met with all the teams and all the deployments and is committed to the hiring. I think it's been three or four at least since there has been any hiring in NDMS. So we are at the point now where people ar cycling through for the second and third time and the same people who go out, they are extended them, asking -- there's people who have been at Harvey, at Irma, who are going on multiple deployments and it's not sustainable.

DR. LARSEN: I had to send a nurse home early because she got so sick on the deployment she was burnt, burnt out, wore down, hadn't had good nutrition, those kind of things and she got pretty sick, so you know, it is what it is.

There has been a lot of changes. The part that I used to serve on, the operational medicine team, was basically dissolved, now they are going to reform it. It's just crazy so --

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DR. PAPISH: You are selling it --

(Everyone is speaking at once.)

DR. LARSEN: This is what I'm hoping --

DR. RABRICH: You haven't lived until you've worked for Federal government, you have to see the way they do things.

DR. LARSEN: I'm hoping some fresh people will come in and, you know, we can push through the changes that are needed to make this a more smooth and viable operation again and bring back some of the good stuff that we had. And, like I said, hopefully there will be money for training and that kind of stuff so these teams will know what the hell they are doing when they go out there.

DR. PAPISH: All right. And you got the where to apply and it will be in the minutes.

Any other new business?

MR. HUGHES: I have our meeting schedule that we have to get approved for next year, only because we need to get the room reserved and get the place so there is only one day that I recommend moving.

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DR. PAPISH: Yeah. It was previously scheduled for September 10th, that is Rosh Hashanah so the tentative change will be to September 17th. Do we have to vote?

MR. HUGHES: No. I want to make sure everybody is okay --

DR. LARSEN: It will conflict with the Westchester REMAC meeting, that's when we would be scheduling it normally, but maybe we can vote to put it the next week for that.

DR. BERKOWITZ: If you make your schedule before ours, we will make sure our schedule doesn't conflict -- take dibs.

DR. PAPISH: We are done. Okay, so January 8th, March 5th, June 4th, September 17th, November 5th.

MR. HUGHES: Yes, all right.

DR. PAPISH: As far as SEMAC report, Pam was there, anybody else that -- didn't we talk about it briefly?

MR. HUGHES: SEMAC -- that was at the State, Andy was there -- Jeff was there --

DR. RABRICH: So we did vote to change the age of certification for EMT from 18 to

17 so that was one big item. They can now sit for the certification exam at the age of 17. There was a lot of discussion, is this appropriate, not appropriate. Lee Burns presented data that all our surrounding states that are contiguous with New York are all 17. The issue they were having is people would take the course and then go off to college or wait six months and they found the pass rate was dropping when the people waited a long time. It allows them to sit for the exam and actually get the certification, it doesn't change anything related to the agency as far as your own insurance policy, driving, that's all agency dependent. But it does allow them to basically graduate high school with EMT card if that's what they choose to do. So that was the big things.

Lee Burns, as everyone knows, is retiring. Donna is leaving as well and there is rumors of several other people. We will see what happens there.

Several members of the SEMAC, several physicians and other members did meet with

the commissioner during that time to discuss their ongoing concerns for EMS, mainly funding for EMS, the replacement for Lee Burns that, you know, they made several suggestions about the type of person they were looking for and continued to push for a State EMS Medical Director. So the commissioner was very receptive, they are planning to have future meetings, but there was no commitment to anything at the time.

Those were the big items, I believe. There were a couple CONs that basically came before the SEMSCO, decisions were upheld, one was out in Niagara, I think, where it was upheld to grant it based on the region's decision. And then for Rockaway, that's New York City, REMSCO had denied was also upheld by the SEMAC and SEMSCO.

DR. PAPISH: Okay, do we have PAD, EpiPen, albuterol, glucometer, nothing new?

Open forum?

MR. VIOLANTE: I just have a couple items. One is that the vital signs conference was just held up in Rochester,

sunny downtown, and the Hudson Valley Region was very well-represented in terms of state awards for EMS. So that was great to have this region well-represented being there, Andy being one, Murph another, Kim Lippes, so that was great. So congratulations to everybody from the region and the region itself, you know, had a good showing.

DR. PAPISH: How was the attendance overall? Are they going to have it next year?

MR. VIOLANTE: I believe it's being planned, but these guys can probably answer that better.

DR. PAPISH: There was a rumor if it wasn't attended well --

MR. ROBINSON: I don't know what the final numbers were. I was not there because I have no staff. So you know, but to the best of my knowledge it's going to happen again, vital signs. Under whose tutelage? I'm not quite sure.

MR. VIOLANTE: The other thing I had is that we are seeing some shortages in some key

areas, IV fluids is one of them and epinephrine we are also seeing a shortage. We are actually reconstituting one to 1,000 to make one to 10,000 as we need to so that's happening.

DR. PAPISH: Do we have any -- forgive my lack of knowing this offhand -- but provision for alternative fluids using LR?

MR. HUGHES: Yes, I believe in the protocol we can --

DR. PAPISH: You can switch them out --

MR. LAMARCA: I think you have to -- REMAC has to approve it.

DR. PAPISH: Oh, you mean --

MR. LAMARCA: The alternative for meds. We had it as well, REMAC could put out advisory to use alternative and I think IV fluids would fall under the same.

MR. HUGHES: There is something in the collaborative protocols on IV fluids that we could use ringers for something, as a substitution --

MR. GARDINIER: At the bottom of the medication form there is an asterisk that

says LR can be substituted if there is a shortage --

DR. ARSHAD: I think there is already interchangeability --

MR. GARDINIER: And then I think we are noticing specifically the smaller IV fluid bags the --

DR. RABRICH: They are in Puerto Rico --

(Everyone is speaking at once.)

DR. PAPISH: Who knew? I read somewhere something like 30 percent of all medications in the U.S. get processed through Puerto Rico at some point other another.

DR. LARSEN: Puerto Rico is not in good shape and the main -- look, you know, a lot of the stuff NDMS, what we really needed was not Doctors Without Borders we needed engineers without borders. A lot more people could have been saved by engineers than me and our teams, that's the unfortunate thing. A lot of the hospitals don't have electricity and --

DR. PAPISH: I thought Tesla was fixing that --

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(Everyone is speaking at once.)

DR. LARSEN: And a lot of these plants, which some of them are more -- their plan is to put -- to do the periphery because that's the easiest. I mean, it's the easiest -- it's also where the main population is centered, but a lot of the production plants are more interior and so those lines -- and a lot of the more local lines, the big heavy duty lines, but the more local lines are total chaos and destroyed. So to sort those out, you know, we may have to think about this shortage --

(Everyone is speaking at once.)

DR. LARSEN: Yeah, a small company that is going to subcontract out the entire --

MR. VIOLANTE: So the protocol reads, D5W 100 ML bags may be substituted for normal saline if there is a persistent shortage and normal saline is not available and lactated ringer's may be substituted for normal saline is if there is a persistent shortage and normal saline is not available. So it's in there, it's an option.

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DR. ARSHAD: So I just have one quick announcement, we are interviewing for a new EMS coordinator, a little different EMS position. So if you all can get the word out we are looking for excellent and highly motivated candidate. So thanks for that.

DR. PAPISH: Any other new business? I just have to read some things into the minutes.

Please advise as the result of an investigation conducted by the Department of Health the following individual's New York State certification has been revoked effective 10/19/17 for violation of Part 800, Greg Monski of Shirley, New York.

Just one?

MR. HUGHES: It's just one.

DR. PAPISH: And that's it. A motion to adjourn?

DR. ARSHAD: Motion to adjourn.

DR. RABRICH: Second.

DR. PAPISH: Thanks everyone --

Does everyone approve the minutes?

ALL: Aye.

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DR. PAPISH: All right, now I would like to adjourn.

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

Yvette Arnold