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HUDSON VALLEY REGIONAL EMS COUNCIL

CORPORATE MEETING

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MINUTES OF MEETING, held at Hudson Valley Regional EMS Council, 33 Airport Center Drive, New Windsor, New York, on Wednesday, December 21, 2016, at 7:00 p.m.

Yvette Arnold,

Court Reporter

ROCKLAND & ORANGE REPORTING

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

RICHARD PARRISH, NREMT-P
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ROBERT CUOMO, EMT-P
Vice-President

NICHOLAS RUSIECKI, EMT
Treasurer

DESIREE LEONE-STOLL, EMT
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DR. MARK PAPISH, M.D.,
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WILLIAM HUGHES, EMT
Executive Director

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KAREN DELAUNAY, Administrative Assistant

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DAVE VIOLANTE
TIM MURPHY
MATTHEW NOLAN
DEE SAGENDORPH
GUY CARPICO

ORANGE COUNTY

ISRAEL KNOBLOCH
DAWN MARSHALL

PUTNAM COUNTY

ROBERT CUOMO
MATTHEW BONDI

A P P E A R A N C E S : (Continued)

ROCKLAND COUNTY

KIM LIPPES
NICK RUSIECKI
MICHAEL MURPHY
DESIREE LEONE-STOLL
BERNICE GARATTI
BJ LEIDNER

SULLIVAN COUNTY

ALBEE BOCKMAN
GREG TAVORMINA
NEIL MEDDAUGH

ULSTER COUNTY

RICHARD PARRISH
KELLY NELSON
RICHARD MUELLERLEILE

ALSO PRESENT

LEE BURNS
KEVIN GAGE
T.J. OLTZ

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(Minutes of meeting already in progress.)

MR. HUGHES: For those that don't know, Station 5 spinal immobilization has been removed from the EMT PSE, after December 31st that will not be a station that is tested anymore.

The office has been working on some stuff with the 9-1-1 dispatch centers. So we have been trying to get information from them and contact information so that we can take a look at what is being dispatched and who is calling who and how the mutual aid works with dispatch.

We had an audit done beginning of the month, it's been completed, the draft has been submitted, it was signed by Mr. Parrish. I sent it back to the auditors so we are waiting for the final documents to come in. Once they do come in they will be uploaded to the Gateway and submitted to the Department of Health, which has to be done by December 31st.

The next SEMAC and SEMSCO meeting will

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be held in Troy on the 10th and the 11th --

MR. PARRISH: That was somebody's phone --

MR. MURPHY: Siri woke up accidentally.

MR. HUGHES: I'm glad that we have a nice quorum and a lot of people, but we didn't know that. So when you get the e-mails drop us a yes, I'm coming, so we can get a quick count. That's all I have.

MR. PARRISH: Jeff, QA/QI?

MR. CRUTCHER: First thing that we will talk about is the website. We are in the process of giving that a serious overhaul. The first part of that has been completed and that's the new training and education calendar. It's a little more robust and I think a whole lot easier to search.

Second thing that we have been concentrating on is EPCRs. And I am going to kind of steal Bob's report at this point in time and do the TAG as well as everything else that is going on. Late January in 2017, the 23rd, 24th and 25th, Image Trend will be here. The first part on the 23rd I'm going

to sit down with Dean Rice and go over a lot of the details about the new Elite Bridge and the implementation and the various things that we can do with it. On the 24th he is arranging for two Town Hall type meetings for any agencies interested in going electronic. He is going to try and schedule one for both the day and the evening so we can catch a fair percentage of the folks that are out there and available. And on the 25th we are going to go visit a couple of hospitals that are already using the Image Trend dashboard for their purposes and talk about how we can start sending some data back to the region and our Regional Bridge and incorporate that into a more comprehensive QA/QI program.

And that is about it.

MR. PARRISH: Any questions to Jeff?

Dr. Papish?

DR. PAPISH: Why don't I go and do REMAC and talk all at once?

MR. PARRISH: Okay.

Training committee, Dave?

MR. VIOLANTE: We have a few things

going on.

First, I would like to thank the region for their training calender updates, that's one of the things we brought up at the last REMSCO. They put it out and worked on it a lot. At the training committee meetings we talked about using it and the REMAC using it and I think a lot more people are putting stuff into there. It's segregated by county as well so you can search based on what you want or need in your county or area and class that you need. So that's useful, thanks to the region for doing that. It's great to have centralized stuff going back that way. So go on there, look for classes, anything from state classes to, you know, your ABC course, to anything else, all that stuff is on there, CME, et cetera.

At the training committee meetings we talked a lot about distance learning options for not only medical control, but training issues, meetings, et cetera. You know, technology is really becoming there now to be able to do that and should make that easier

for others to join in on training and education and seminars and that sort of thing because of technology. So that should help to bridge the gap for a lot of areas where people have problems getting out and going to some of these things where they are because of obligations and other impacts on schedules and time.

We are also talking a lot about intergenerational learning, making sure we are using flipped classrooms and experience in the training and education and not just standing up there going waa, waa, waa, waa, waa. So we are doing a lot of work on that on the training committee also.

I do have to say kudos to Laerdal and members of the protocol committee. They did a lot of work on the collaborative protocols and filming different special consideration scenarios, all that was hosted by Laerdal. So when the protocols come out, in terms of education that Bill was talking about, we will see some of that stuff and it's a lot of good stuff from people around the region.

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And we got a lot of support from this region so kudos.

And that's what I have unless anybody has any questions for me? Nothing? Okay.

MR. PARRISH: All right, Dr. Papish, now you can have it.

DR. PAPISH: Okay, I just figured -- actually there were a couple things I was going to touch on that he said so I'm glad I went second.

Just to summarize the REMAC and touch on when he was talking about the carfentanil, there was -- I don't know of any autopsy driven data that carfentanil is here. But there is enough of a prevalence in the United States and enough overdoses in our region to think it probably is. And we never sent out any kind of REMAC advisory about it, but be aware that the amount of Narcan required to reverse carfentanil is significantly more, 16 milligrams -- I mean to reverse an overdose. And there are very few case reports where people actually are, you know, touching carfentanil because really it's

living in drug labs primarily. The one case report that I've read either resulted in fatality or the person that touched it in an experimental situation where they were doing research immediately got 30 milligrams of Narcan over an hour and basically never developed any symptoms so it's really kind of a big unknown. But the implications are these patients might not be reversed and it stresses the fact that narcotic overdose management essentially is the BLS airway management and good ventilation.

So at the last REMAC meeting there were a number of items that we discussed that I think are pretty pertinent. One was the creation of the pod casts and the new protocol orientation -- and the collateral protocols coming out I think are really good. For those of you who have read the version that is coming out, the big thing about the new protocols that I think are really cool is -- it's not really a huge change -- but the REMO protocols are really evidence based, which is -- or at least the majority of the

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discussions around the development of the things they are doing. And the important thing, I thought, one of the things I touched on with regards to Narcan or with regards to -- well, I lost my train of thought.

The fact that they are evidenced based we are sort of moving in the world in health care to an arena of big data. And the more data you have the better you can actually move forward and develop good evidence.

One of the things -- I don't know our percentage of people on EPCR -- but the whole idea of EPCR is that we can get big data and decide ultimately what works and what doesn't and make recommendations in the protocols that really make sound sense. So the more people or more agencies we can get on EPCR, the better. That was one thing.

We sent out a pediatric trauma advisory. I don't know if anybody got that in the mail. I wanted to just touch base on that. The pediatric trauma advisory, the idea, if you look -- if you look we see pediatric patients that meet the CDC anatomic and physiological

criteria, not necessarily the mechanistic criteria and we transported primarily to a pediatric trauma center. There is enough data to show that the secondary transport times are just too great for when patients are critically ill, when children are critically ill, to get them to a pediatric trauma center. So we sent out this advisory and I'm hopeful that it will increase the number of primary transports to pediatric trauma centers, recognizing the limitations in our system, that we do have a big area and it's difficult to take an ambulance out of service. Part of the whole point of the advisory was to increase the use of a helicopter in these children that meet sort of anatomic and physiological criteria, not sort of -- those are all critically ill children by definition, they are all sick and so we really want those patients at pediatric trauma centers. And these are patients that we shouldn't really have hesitancy to use the helicopter for, if that's the easiest way.

That centered a conversation at REMAC

about using helipads of hospitals to get patients secondarily transported. Some people voiced concerns no one wants to wait on scene with a sick child. And one of the discussion points that ensued is heading towards the closest hospital and having the helicopter land there if that's easier. That will be something we are hopeful will start sort of a hospital initiative in the region. Westchester Medical Center, Mid Hudson Regional is in the process of creating some language to allow that to happen at our helipad for anybody. And the idea is not to have the patients go into the hospital, it's to use the helipad. But in the event the helicopter is not there you have an out, you can drop them in the hospital and they can stabilize them and get them on the way to a pediatric trauma center as fast as possible.

Were there any questions about that? I'm sort of anticipating some --

MS. SAGENDORPH: At the DCC connection I sat in on lecture by a gentleman who is a helicopter medic. And he said that was a big

discussion in our group that day about using that idea and getting to the hospital, okay, and meeting the helicopter there. And he said that they do that. They are doing it more and more in his agency so it's a doable situation.

DR. PAPISH: Our hope is other hospitals in the region are going to sort of adopt -- you know, sort of -- I believe every hospital has to sort of opt into this. No one is going -- there are obviously people that have concerns about EMTALA. There is a carve out in EMTALA for this as long as it's part of a regional protocol. And that's one of the things we voted on is that if we have language within our Hudson Valley Region that accommodates that there is no EMTALA concerns on the part of the hospital. It's carved out specifically for this purpose to use the helipad as evacuation point to get pediatric patients to trauma centers. Hopefully that will kick in.

MR. PARRISH: After REMAC there was a discussion about what is a pediatric patient,

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there are a couple different definitions.

DR. PAPISH: Right. The New York State defines it as secondary signs of puberty. And this is a difficult -- this is something that will have to evolve over time and be sort of carved out. Secondary signs of puberty in this day and age and this is -- you know, that's a protocol stipulation and -- it's a difficult -- you know, there are nine year olds in this day and age that are at puberty, but I don't think anybody would argue that a nine year old should be treated like an adult and vice versa. So various agencies across the United States use different ages as a cut. The ACS or most -- I believe ACS recognizes 14 and under, but this isn't something there is universal agreement on and something I think we discussed and said we would work on it.

MR. PARRISH: It needs to be looked at, yeah.

DR. PAPISH: That's an issue to get addressed. At the end of the day there is certainly an arbitrary cut point between 12

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and 15 at which somebody is physiologically much more of an adult. No matter what we do, whatever set point we make, we are going to have a little bit of error on one side. Nothing is going to be perfect, but to come up with best accomodation is something to look forward to.

The other issue we were talking about is the narcotic epidemic. Was it 60 percent, was it, of our agencies are Narcan enabled? So how we can get the other 40 percent if your agency isn't Narcan approved or using Narcan, talk to us. In this day and age there is funding for it, the training is free. And barring the atomizer issue we can get the drug, so the drugs are free. So there is really no reason not to have a Narcan program at your facility and it's certainly beneficial. So whatever we can do to optimize that will be in all our best interests.

And the last thing -- sorry -- maybe I should have had you breakup the monotony, Dave. There was one last thing, I think.

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Narcan, helipad, pediatric trauma advisory, new protocols -- and oh -- just Ketamine. That New Windsor has a ketamine protocol. Any ALS agencies that don't or are interested, it's sounds like ketamine really is quite effective. And, I mean, that would be something that would be, I think, a benefit for the excitement delirium patients in the region. Anybody interested in having it, if the medical control directors are hesitant to, let us talk. That's it.

MR. PARRISH: Any questions of Dr. Papish?

If not, transportation committee? No report.

Public information and education?

MS. LIPPES: No report.

MR. PARRISH: Policy and procedures?

MR. TAVORMINA: Nothing to report.

MR. PARRISH: Legislation and bylaws? Albee?

MR. BOCKMAN: Ready to report.

First and foremost, Merry Christmas, Happy Hanukkah to everybody.

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I have nothing on the agenda for any additions, changes to our bylaws. But I do have a couple of things of legislative level I would like to inform you -- as I always do.

There is a bill in the Assembly right now to have training for firefighters, police and EMS personnel involving individuals with autism spectrum disorder. Training is going to -- it has not been signed on by the Senate yet, but they are doing that all over in places that have these type of individuals with this disorder.

Anyone that is interested in the region, in Sullivan County is an agency known as Sullivan Diagnostic Center, the Center For Discovery. It employs 1,500 people and it's a community of autism clients. And they put on these seminars for emergency personnel, we just had one a month --

MR. TAVORMINA: About a month, six weeks ago.

MR. BOCKMAN: -- about a month ago. I would say there were a hundred people there. We are proud to say in one of our little

communities where I happen to live they built this tremendous art center. And it has an auditorium that holds 138 people, most modern of equipment. And I have been informed if our region has any interest in putting on a seminar for autism, they will get the instructors and we can utilize that art center for it. It's tremendous presentation and it would be definitely advantageous for us all if you have an interest. So there a bill in the Assembly right now that we are putting together training and we have it in our region.

MR. MURPHY: Is that going to be mandatory?

MR. BOCKMAN: It's a bill, let me just read it to you really fast. To amend the Mental Hygiene Law, Executive Law and Public Health Law in relation to a training program for -- on handling emergency situations. It does not say it's mandated, but it will be part of the Public Health Law where the training will be there for it.

Secondly, there is a bill in the

Assembly and it's also been signed on by the Senate and it's been referred to the rules committee this past November 14th, that they are going to amend -- hopefully amend the Penal Law in relation to designated offenses against law enforcement officers, which includes a definition of EMS personnel and firefighters, as hate crimes and assault against us as hate crimes. With that, the other bill in the Assembly is to upgrade the charges for anyone that has been charged with that to a Class B felony, which would be mandatory imprisonment -- good for us.

Those are the three things I have to bring to your attention. That is the end of my report, sir.

MR. PARRISH: Thank you. Devereux Foundation in Dutchess County, don't they do autism training?

MS. SAGENDORPH: Devereux is not, Anderson Center for Autism is located in Staatsburg. They work closely with our fire department. We volunteer a lot down there for different things for the children so

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there is -- that's another good source out there so -- and they will also do training.

MR. PARRISH: Very good. Any questions of Albee? If not, EPCR committee? Has that been handled?

MR. CUOMO: It's pretty much taken care of by Jeff --

MR. PARRISH: Okay.

MR. CUOMO: -- hang on a second. I just want to make a pitch, being that I'm chairing this committee right now I would like to make a pitch if there is anybody else that is interested in chairing this committee, feel free to let your interest be known. Because, you know -- believe me, I don't mind chairing it, it's just that starting in January I'm going to get a whole lot busier in my primary job and it maybe difficult for me to stay on top of this. So I'm willing to stay where I am right now, but if someone is willing and interested in chairing this committee, let Bill know, or Rich, or myself know, and you are more than welcome to it. Just saying -- and that's really all I wanted to add to

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that.

MR. PARRISH: Don't come rushing.

All right, community para medicine. Mike?

MR. MURPHY: We are going to take another stab at it in the calendar year 2017. The next State Council meeting is the 9th and 10th. We have arrangements to have a meeting with the various associations NYSVARA, fire chiefs, et cetera, to try and look at taking another stab at getting the verbiage changed in Article 30, which was attempted last year the previous legislative session and it was met with obstruction by NYSNA and the home health aide organizations, so we are going to take another attempt at it.

MR. PARRISH: Okay.

DR. PAPISH: Agencies are doing it --

MR. MURPHY: Agencies are doing it in various ways. I mean, like everyone down in New York Presbyterian is doing it on the back end. It's on the discharge end, so in other words -- and that's -- that can be done. The issue is -- and I call that the back door of

community para medicine. The front door is the alternative destinations, paramedics and EMTs operating outside of the emergency venue, let's say, just going to a person's house and doing a well check. And that's where we have need the verbiage of Article 30 to be changed, otherwise we are operating outside the scope of practice.

DR. PAPISH: It's interesting because the agencies are doing home checks now post discharge planning, but it's -- what would make that -- I mean, I'm an advocate --

MR. MURPHY: So am I --

DR. PAPISH: -- with regards to the law what would make one separate from the other?

MR. VIOLANTE: Not being in the hospital to start with.

MR. NOLAN: From the programs that I've seen it's more environmentally based, not the patient having complaints. So is it suitable for their condition? Is there someone there to take care of them? Is there -- have they filled their prescriptions? That type of thing.

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DR. PAPISH: There is no --

(Everyone is speaking at once.)

MR. MURPHY: Kevin Pensacola discharged -- if they take -- ambulance crew takes somebody home, actually does an assessment for trip and falls and safety. And who is the caregiver? Does your refrigerator have food? Did you fill your prescription? If not, we will go get that, stuff like that.

MR. CUOMO: They are doing that on the transport home?

MR. MURPHY: Or the day after. But again, it's not necessarily done as a medical intervention, it's done more as a safety check. It's camouflage, you know. But the true emphasis of community para medicine is to deal with a complaint on the front door and be able to make a decision using medical control does the person need to actually go to the emergency department? Can they go to primary care? Can they be taken somewhere else? And that's going to require a change in the law.

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DR. PAPISH: Some of the colleagues -- I was speaking to somebody yesterday -- are developing curriculum for like an educational block about community para medicine. So the training is getting developed too, we just need to get it through the nurses union.

MR. PARRISH: Any other questions of Mike?

State EMS Council. There has not been one since our last meeting, the next one is in January.

All right, old business? The TAG mutual aid update?

MR. BOCKMAN: Chairman LaMarca was unable to attend tonight's Regional Council meeting, he has another engagement in Dutchess County. We have communicated and I'm speaking on his behalf.

We had the TAG committee meeting on May 10, 2016. It was understood among everybody that the EMS coordinators were to finalize the mutual aid plans by the end of this year. And further, that all parties that are on the committee understood that we

would meet in the first quarter of 2016 and those plans would be presented before the TAG committee for the review and final approval by the Regional Council.

I did send out an e-mail to remind everybody that any of the EMS coordinators that are here tonight should report on the status of those mutual aid plans. Further, that if they are not prepared to do so -- and I will say thank you to Putnam County that we did receive from them and their mutual aid plan -- that they are to finalize their plans by the month of March and present those mutual aid plans at the next meeting, which will be in May of 2017, here in this room.

And we request that you coordinators do that and we ask that the executive board here direct that that be done.

MR. TAVORMINA: Mr. Chairman?

MR. PARRISH: Go ahead.

MR. TAVORMINA: From Sullivan County's perspective the plan currently being worked on, it will not be submitted until it's been vetted by all proper county agencies and this

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body has no authority to set time frames for submittal of plans from a county agency.

MR. PARRISH: The way I understand the -- you have something, Karen -- not Karen -- Kim, are you just scratching?

MR. TAVORMINA: They can request, but this council has no authority to mandate a timeframe.

MR. PARRISH: I would have to go back and review Article 30. I believe that we have to approve them, but as far as mandates for time and all --

MS. LIPPES: I believe it's policy statement 1206. We went through the whole process, ran up to the council, I believe you were on the committee, so Rockland County is square. Everybody signed on board, I think, two, three years ago. I don't know there is a time frame, Greg, but just FYI, you need it --

MR. TAVORMINA: I know --

MS. LIPPES: When we had FEMA come during the storms a couple of our agencies were not entitled to --

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MR. TAVORMINA: I'm not saying we don't need it --

MS. LIPPES: It's just a benefit --

MR. TAVORMINA: It's going to be done, but the time frame it couldn't be done by March.

MR. PARRISH: I think the committee was trying to put time frames because it's been dragging a couple years --

MR. TAVORMINA: Ten years.

MR. BOCKMAN: That's the point that we spoke about, that we have given everybody enough time to do their responsibility and put a plan together. That's why I said that the committee requests that it get done by March. They have had plenty of time to put this together and that's your job. So we are requesting at this time it be done by March. It's pushing into May, we are talking over six, eight months we have had since we initiated the committee. It's enough time.

MR. PARRISH: Yep.

MR. BOCKMAN: We all know everybody is busy and have responsibilities. However, our

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job here is a responsibility as well and that's all we do is request they get it done by March.

MR. PARRISH: Please make every effort to meet those dates.

MR. MUELLERLEILE: I'll speak for Ulster. The EMS coordinator's job, yes, is to administer this, is to develop and administer. But honestly, if you don't have input from the boots on the ground out there, you know, I mean, we don't have -- so Ulster, for instance, very little interest or involvement by the committees in EMS Council in Ulster, Rich can confirm that. There hasn't been quorum at EMS council meetings, which is the first line after the plan is developed from -- you know, either a collaboration of myself and Ulster County EMS Council, or just myself, it should be going to the EMS Council for vetting. And the EMS advisory board has seemingly dissolved -- poof -- believe it. So you know, the unfortunate part about it is I can create 20 pages documents overnight, but the issue

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we run into is if we push something and don't have the buy in from the boots on the ground and this obvious effects them, you know, it could be a big deal.

MS. LIPPES: Well, 1206, if you look at the tail end of it, it's like 68 pages and the first two are filed out by the agency and coordinator to confirm and up to the regional level. And, trust me, I understand about chasing agencies because I think I ran about three pair of shoes raw trying catch them. I basically said, here is a date, you fill out your two, I filled out as much as I could for them. I got the certificates and filled it out -- as crazy as that was -- and said, here it is. You need to fill in the blanks and modify if there are corrections I didn't catch. I said, if not, I'm submitting it forward. But remember not only is it the FEMA money -- that was big thing a couple agencies really got caught on this -- it's the response area. They shouldn't be going out of their boundaries without something in writing. So if they want to get caught by

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Medicare you know, looking for reimbursement of funds they shouldn't be billing for, that scared a bunch of people. And we beat ourselves up for a year, back and forth --

(Everyone is speaking at once.)

MS. LIPPES: -- and we chased them. But, again, we reminded them, gave them the forms, said fill out the two pages. It's not really hard, it's basic information on the two pages.

MR. MUELLERLEILE: The mutual aid response plan for the county is more than just the 1206 worksheets and that's the problem. Because now -- yes, I can have one of the agencies in my county fill out a 1206 worksheet, boom, okay, so we know who you want to utilize for -- that has operating authority in your jurisdiction and does not have operating authority, but what it doesn't do is a lay a framework for the -- which is a huge task --

MS. LIPPES: We were fortunate that we had Homeland Security grant money that helped us assist on that end --

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MR. MUELLERLEILE: Can I have them?

(Everyone is speaking at once.)

MR. TAVORMINA: If I can?

MR. PARRISH: All right, Albee?

MR. BOCKMAN: Rich, your concerns are well-noted. And you're new in your position here and new in your position in Ulster and the people before you did not follow through with their responsibilities as well, we all understand that, everybody understands that because we have lives to life as well, as volunteers and non volunteers it's difficult.

However, as it was said -- Greg said, it's been two years, it's been five years, it's been ten years we have been discussing this and the time is now. Kim laid it out perfectly. We have that responsibility and we can come up with every excuse in the world. And we are not here to demean anybody, but the time has come. We have given everybody I don't know how much time discussing it. We put the committee together and there were months before we had the committee that they needed it to be done and,

respectfully to you, you are new. The time is now and we are asking everybody to please do their job and get it done. Kim is right, it's mandated. You have Medicare that is involved now, reimbursement issues. It's serious and real. It's a mandate from the Department, 1206 tells you we have got to have it. We are just asking everybody, dig in. Boots on the ground, if you cannot get your boots on the ground to work with you, you have other issues to deal with. If you have an advisory board, that's legislative level in the county, deal with that and tell them I'm having trouble, let them get on the squads inside.

But whether or not we can mandate a time or not, time has come. It's now your responsibility to get her done.

MR. PARRISH: Greg?

MR. TAVORMINA: Two points. One, personally from Sullivan County, I sent out the 1206 to agencies numerous times. I've only had one respond back to me. And with respect to the county mutual aid plan, I have

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to be extremely careful about how it's worded and vetted because there are legal issues with the county and agencies, us being sued over mutual aid dispatch in the past -- no specifics, but leave it at that. That's why the delay, I have to be extreme careful.

MS. LIPPES: To protect yourself give the agencies a deadline from your end. Say at this point, if you haven't participated I'm just going to report it up the chain and tell the region. Say, you choose not to follow this policy, that way you are covering yourself if somebody comes back to you and says you didn't do something, here it is, this is the date, they refused to sign on. You explain the ramifications if they don't do something.

We had a couple agencies hold out and when they realized they were going to possibly be in jeopardy for something they came scrambling at the tail end.

MR. TAVORMINA: I'll give it a --

MR. VIOLANTE: If you don't have Dutchess County we will send you the most

recent version. We will send -- the last was a 2010 timeline we --

MR. BOCKMAN: Just requesting, if the committee wants it done by March it will be a year and a half by the time we discuss it initially, I think you understand the point.

MR. TAVORMINA: I'm not disagreeing it needs to be done --

MR. BOCKMAN: I know that and I know that we are trying to be diligent.

MR. TAVORMINA: So I'll have your 1206 next month?

MR. BOCKMAN: Absolutely.

MR. PARRISH: All right, closing out old business, the collaborative protocols.

I have a letter from Andy Johnson. This letter is to verify that you are approved to utilize 2016 collaborative protocols submitted at the May 2016 of SEMAC REMSCO and that they were approved in their entirety without revisions.

The meeting schedule for next year, there are two dates we need to discuss. Wednesday, September 20th needs to be changed

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that's Rosh Hashana, and Wednesday December 20th -- Hanukkah is December 12th through the 20th and Christmas is December 25th. So do we want to go to a November meeting? Any suggestions?

MS. SAGENDORPH: We have to change the September 20th, right?

MR. PARRISH: Yes.

MR. CUOMO: Can we go a week early or late?

MS. SAGENDORPH: I don't know about anybody else, I would prefer to change the December to November as long as it wasn't the night before Thanksgiving.

MR. PARRISH: Let's get the September 20th one, suggestion was the week before or the week after.

MS. MARSHALL: Probably the week after. The week before is Patriot's Day, the memorial is that week. So September 27th, Wednesday?

MR. PARRISH: All right, any issues with the 27th anybody knows about? All right, the 27th.

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And the 20th, move that to November was the suggestion.

MS. MARSHALL: November 29th, that's the last Wednesday of the month after Thanksgiving.

MR. PARRISH: So the 29th?

MS. SAGENDORPH: That's the following week after Thanksgiving.

MR. PARRISH: Yeah, after Thanksgiving.

MR. CUOMO: Rosh Hashana is when to when?

MR. PARRISH: So 11/29/17. Okay? Very good.

All right, Ms. Burns, do you have anything you would like to say?

MS. BURNS: Just a couple quick things.

I don't know whether you talked about this before, but the Governor signed a significant change into Article 30 with regard to Epi-pens, which broadens those entities that can utilize Epi-pens. What we are in the process -- this may make you very happy -- but we are in the process of trying to figure out is, we think that the

statute -- the new statute eliminates the notice of intent and the reporting to the Regional Council, which -- or the programs, which is actually a pretty big deal. It also makes getting training to non regular EMS entities a little more interesting. And we are sort of trying to feel that out. So it actually -- I can send you all the verbiage, or I'll provide it at the State EMS Council, but it goes into effect at the end of March. So that is big doings and in my office they are all like, why didn't they do this to defibrillators too? But besides the notice it interestingly pulls out the emergency health care provider and it turns to individual prescribing practitioners, so physicians, nurse practitioners, PAs, basically anywhere you can get an Epipen from. It is very very specific to Epipen, so if your brain is somewhere in the check and inject phase, we have really been dogmatic about keeping that for EMS. So we are -- check and inject is EMS project, not a general public one.

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The second thing, which almost doesn't affect you because you guys are revolutionaries in this regard, but we sent out the other day a letter -- which, Bill, you should have seen a copy of -- to about 66 remaining advance life support agencies in the State that do not have controlled substance licenses. And we have given -- and the we is the Department and the SEMAC -- we have given them a February 1st -- I can't use the term that I am -- I'm most likely to use -- but deadline to submit an application. And if they do not, with working with the REMAC and, frankly, the regulations, we will -- they will end up either looking towards advanced EMT or basic EMT provision of care. I mean, really in the big picture of 600 ambulance services having 66 remaining is pretty remarkable, we are pleased about that. A couple SEMAC docs, not so much, but -- we are trying to streamline some of the reporting processes for our controlled substance license holders and that's been a fight with our partners at the DME. I don't

mean that literally. We were hoping to consolidate your reporting to twice a year, they really wouldn't let the fentanyl and ketamine quarterly go. We continue to kind of pick at them about that.

And other than that, I don't know. What am I missing?

MR. PARRISH: Can you address the big statewide infection control or infectious disease exercise starting in February? And EMS is supposed to have a significant role in it --

MS. BURNS: Peripherally, I'm not -- we know it's going on. We know that the counties have been contacted. We know that there is some EMS injects, but I've not actually seen what the plan is.

MR. PARRISH: They haven't released a plan, but I was on a conference call last week that described it and says we have to -- at hospital level we have to have county health, OEM, nursing homes, EMS involved and they haven't rolled out the plan. In fact, they are keeping it very close to their

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chest --

MS. BURNS: We are supposed to be providing injects and we have gotten no information on that. So the answer to your question is, no, I have no good news on that.

MR. PARRISH: One of my concerns and I advised before, is the hospitals, nursing homes, they get grant money for this. And they come out with, you know, the Ebola plan, the burn plan, that EMS is supposed to be heavily involved in, but we don't get any of the grant money.

MS. BURNS: The hospital -- I can't speak for long-term care because I just don't know, so I can't make -- specifically, honestly, a lot of this is unfunded mandates, there is not a lot of grant money left. You know, the Ebola thing we can talk about forever. My -- when we looked at what they had envisioned for EMS for the Ebola response was every EMS agency would have a designated officer and, of course, every EMS agency would go out and buy all this personal protection at the tune of zillions of

dollars. What we said is, first of all, it's unreasonable. And, secondly, not practical. And, thirdly, it ain't going happen.

So what we worked on with a lot of our bigger ambulance services is a regional approach. Because in addition to not being funded up front, there is really no reimbursement either, so the fun continues.

MR. PARRISH: I know, like my hospital in order -- we are mandated to participate, but by participation we get $12,000.00 in grant money. It's not an awful lot, but EMS, they are not getting anything.

MS. BURNS: What I did neglect to tell you, which is absolutely huge -- and I say this at the State meetings for those of you who don't watch that webcast, God knows -- the State is in the process of really reconstructing the statewide trauma program. And the hospitals and I cannot -- the State Trauma Advisory Council, which is another of our advisory bodies in consultation with the Commissioner, decided that all of the trauma centers should be ACS, American College of

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Surgeons Committee on Trauma verified and it's been a process that's been ongoing really since 2012 and the success is absolutely breathtaking. Right now there are 22 hospitals across New York that are verified by the College.

In the good news for you here locally, is that St. Luke's completed its verification visit. It's never been a trauma center before. The committee came in and found insignificant deficiencies and they are just waiting for the final high holy papal blessing of the College. And I think they are going to be a level three, which, you know -- you know St. Luke's, it's a lively little urban trauma center. And I think having it as a trauma center here is good for patients in this area, but it's awesome for EMS. And they are very very excited. When I thought the meeting was last month I was still coming down because I went and visited with them -- so the hospital is thrilled and the minute they get notified by the VRC you will hear about it because I think they will

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have helicopters spinning banners in the area --

DR. PAPISH: Us too.

MS. BURNS: Mid Hudson is -- you either had your visit or --

MR. OLTZ: We had our visit on the 14th and the 15th, it was all encompassing at the hospital. The two day visit was very successful. And during the debrief we had no level one deficiencies, which was amazing. They felt we had a very strong group with our trauma surgeon and our trauma program manager that we would -- that we had made significant improvements from their last visit. And in 14 weeks we expect to get verified as being the only level two trauma center between Westchester and Albany.

MS. BURNS: Albany just finished its visit for level two pediatric, so, you know, we are working on Orange Regional. I think that, you know, it's really exciting. It's good for trauma patients -- if you have to be a trauma patient. But the process that the College -- the College, as he just said, they

come in and they look at the entire infrastructure of the hospital so that the trauma service may reconstruct itself and develop all kinds of processes, but it involves absolutely every department in the hospital, from dietary to housekeeping to the labs to step down units, to monitor -- you know, the whole system is looked at. And, again, it is -- the credit goes totally to each individual hospital. Because it is, as I -- I say to the Trauma Advisory Council, you know, I'm not your average idiot, I'm an above-average idiot. What they do to get people involved in this is epic. And I think, again, the effect for the EMS system is only good.

And speaking to Dr. Papish's point about getting pediatric trauma patients to the right place, this makes it -- this puts you and the hospitals in the area absolutely on the same page. That's me thumping myself. I'm also, by the way, the trauma coordinator. I keep telling them be afraid.

MR. PARRISH: All right, any questions

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of Lee? Kevin, you got anything?

MR. GAGE: No.

MR. PARRISH: And I forgot your name --

MR. OLTZ: We basically covered with Mid Hudson Regional having their ACS visit, that was a big major thing we wanted to get out to everyone. And we will know in 14 weeks when we get our verification that it will be public notice that we are, you know -- and we are, you know, things will be coming down for trauma services in your hospital. You know, we are working on having, you know, auto launch the helicopter for pediatric patients, getting the pediatric patients into the emergency room, stabilize them and getting them down. We are wiring all our trauma rooms right now so the trauma surgeons for the pediatric patients can see the actual trauma patient in our trauma base while we are resuscitating them. And they will know what they are getting before it even comes down, before it leaves the hospital.

MR. PARRISH: All right, at the last meeting Dave brought up a suggestion,

recommendation that we need a regional system discussion group, you know, and we have gotten to the thing with mutual aid. How do we get the BLS organizations involved? We do have some regulatory things we do for ALS, but there is not much we can do with BLS, folks. And I know Rich touched on it, in Ulster County they are out there, they don't think they have to participate in anything, they follow their own rules. We need to get these folks together. And we have a region that we have to look at. And Dave brought it up about we need to start looking at this stuff. If you have got anybody that is interested? I know I'm interested.

MR. VIOLANTE: I think food is the answer.

MR. PARRISH: Is that it? Lee?

MS. BURNS: I'm glad you brought this up, but you skirted something that is really actually unbearable. And that is, first of all, if there is something that you can do, BLS agencies have the same statutory responsibility as ALS. But what is happening

across New York is that our -- I know this will come as a shock to everybody -- but our EMS system is extremely distressed and our EMS agencies are hanging on by a thread and there are some of them who are a little more transparent about that, but most of them are dying and you don't know it. And I think that putting together some sort of a system evaluation at the Regional Council level would absolutely be huge. Because what -- what we are seeing every single day are ambulance services closing and they are dying at an exponential rate. And what is left is scorched earth and surrounding EMS agencies becoming more stressed because now they have to carry on and answer more calls and they don't have the excess capacity or, frankly, fat to be able to do it.

And when we start talking about the agencies everybody says, well, it's all about the money. It is all about the money to some extent. There is two problems with this, one is obviously financial, and the other one is resources. There just aren't people out

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there, you know. If somebody says to me how many EMTs are there in New York State? There are just under 60,000 EMTs certified in New York State, but when we look at who is actually out there answering calls we come up with -- and it's, again, above-average idiot -- statically we are looking at about 28,000 people answering EMS calls. What we can't tell though is that each and every one of you are doing it in more than one agency in multiple counties. The average EMS provider is working, riding, volunteering in at least two services. So now we are down to 16,000 providers.

And, honestly, I don't -- if you guys have some thoughts, you have some energy, you want to start beating the pavement a little bit and engaging your EMS community. Anything, anything, you can think of because the future is very very dim, honestly. And it's -- again, you know, years ago when I met Albee -- so 150 years ago -- you know, the question put to me at that time was, you know, well, what about the commercials and

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what about the volunteers? It's across the board. The same commercial ambulance services can't find EMTs to hire, the volunteers are disappearing. And, honestly, we are looking statistically that our EMS providers are frankly aging out. You know, they are my age, you younguns should be glad --

MR. BOCKMAN: Where does that put me?

MS. BURNS: Well, you are just tougher than the rest of us.

As you know, at State level we have been talking about the critical care level and there is a lot of consternation what is the State going to do? We looked at the average age of critical care providers and why do you have fewer and fewer EMT CC as opposed to EMT PC, or really EMT threes are aging out and that's why the numbers are dropping.

So I think, you know, in your -- your region is not immune to this, as you know. We have Kevin taking residence up in a community in Orange County that he loves so much. So we are at a breaking point here, it

would make sense if you could -- if you have any input I would appreciate it because people say, what are we going to do? And I just don't know. I don't know.

DR. PAPISH: Do we ever market this? If you think about it, as a company that is not getting business, we take ads out. And I know -- I don't know where the funding would come from, but I've heard this -- you know, this is not a new issue. It's been an issue since I was a paramedic, it's been a long time --

MS. BURNS: A couple years.

DR. PAPISH: The point being, other than you know, some volunteer in your town, like the local agencies put up the signs, I don't see any marketing. Maybe -- I don't know if it's Department of Health funded, you know, but this is -- asking people to volunteer is very difficult in this day and age when everybody is working all the time. But some sort of marketing campaign would be -- I would like to drive up volunteerism in general. Maybe there is a marketing

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campaign, I don't know. I just haven't seen signs --

MS. LEONE: One of the problems is we are getting 40 plus people signing up for EMS, but can't pass the CPR exam and you can take three or four times. I don't think it's not we are getting people, we are just not getting the right people -- at least in Rockland in our classes.

MS. BURNS: You need to --

(Everyone is speaking at once.)

MS. LEONE-STOLL: -- they have everything read to them and they come to EMT class expecting the same classes.

MS. SAGENDORPH: CFR is the same way. They don't have the wherewithal to sit down and read a chapter and understand -- and understand what that chapter is about.

MR. PARRISH: The class I just finished, they came in with the attitude they were entitled, they didn't have to follow the rules and regulations.

MR. TAVORMINA: Quick question, is there anyway that your office or department could

mirror like fire service does?

MS. BURNS: We can certainly talk with OFPC, but they didn't have an unbelievable result with that either. Everybody is all over me, you, people in the Health Department have made the EMT class too long. So my comment back is, we'd gladly shorten it, but what do you want me to take out, chest pain, difficulty breathing, hemorrhage control --

MR. RUSIECKI: Spinal immobilization?

MS. BURNS: But the thing of it is that then I chat with my colleagues at Office of Fire Prevention and Control and our EMS classes are, as you probably know, 160 hours give or take, but firefighter one is what, 180 hours? I was like, really?

MR. TAVORMINA: That was reversed, they split firefighter one basically back to fireman ship and then you can advance, it's cut down to 48 hours.

MS. BURNS: But, you know, we are also in the process of -- you know, we have got a couple of things going on. And I don't know whether you have done this locally, but there

is a lot of distance learning possibilities. We had got -- Hudson Valley Community College has a relationship with North County Community College in Saranac Lake for para medicine programs, there is a lot of things going on. You know, we are experimenting with didactic training, distance learning, didactic training, and then setting up multiple skills sites so there is a lab instructor in five different places on a given night, so if I'm closer to here I can go to that station and work with the lab instructors.

But the problem is and I -- you know, I guess -- I've reached the point where I've got hair on my heart about this. We can only -- to Desiree's point, we can only accommodate to a certain point because there are people out there practicing medicine on people's families. It's not a small task, you know. I don't -- I don't really -- you know, I'm conflicted. I don't really want to make our education process so mind-numbingly brainless that when the EMS provider rolls up

on the scene for somebody sick they just don't know what to do because they missed that section on their Lazy Boy and IPad. So --

DR. PAPISH: I don't think dumbing it down is the answer.

MS. BURNS: Yeah. We have been very resistant to basically on-line paramedic programs that are conducted in a college out of state. So while these people were actually nationally registered, they took the registry and passed it, they did not do what they needed to do to meet New York State qualifications. You know New York, we are right on the cutting edge. You know, so what we said to them was, we will let you take the practical skills and written exam. And they said, oh, God, no. And then they took a refresher class. This was three people, two of them brand new paramedics, national registry card, correspondence paramedics, took the paramedics refresher course and failed the exam and they are not certified in New York.

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So, I mean, I guess there is value to seat time to a great extent, but I think there is a value to actual hands-on interaction. And most of you are paramedics, you know this. How do we shorten or make being a paramedic easier? I don't think we should be --

MR. PARRISH: Dave?

MR VIOLANTE: This is some of the stuff we talked about a at training and ed program committee. And one of the things that we put on the agenda is centered generation learning. I brought that up earlier as one of the things we talked about on the heels of some informational pod cast and book by Tim Elmore. So on the one hand we do have to change not just education, but agencies and organizations understanding, the group of people out there now coming into our programs. Because we cannot treat them the same way as we have been treated or have the same expectation from education, from policy, from procedure, all that sort of thing. Yeah, we have some agency expectation, but

getting them to the point of internalizing it is a different process than for us. For a system that is 30, 40 years old, we are trying to do the same thing.

And in Dutchess County we have EMS task force looking at this county wide. We have a tremendous amount of work we have done. And thanks to the County Executive for spearheading this whole process. I think if the region went to that group and said, how did you do that? Let's do it at the regional level. You would have great support to doing that.

And we have a different vision for EMS. I think our EMS system fundamentally is going to have to change, which will include alternate care destination, changing ideas about what patients are truly patients and what we can do, to Mike's point about Article 30 changes and what we do as a group considered to be prehospital care. Technology has changed, our understanding of how things work and funding and all that has changed, but we have not. So if we don't we

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are going to go by way of the dinosaurs and --

MR. PARRISH: Yeah. My first thoughts would be that the EMS coordinators should be involved in the group. I definitely would like to be involved in it. And definitely training, we need to start looking at what is going on in this region and Lee addressed a lot of it. So we got to start pulling together somehow.

Albee?

MR. BOCKMAN: If I could just have the last sentence? The boss is right, we are not the only ones in the entire State having this problem and we need to do surgery on the entire EMS system. But right now -- right now we know we have a deficit in the region in getting EMS personnel out of the base. So we need to put a bandage on this. And that's why I'm stressing again, my last word of the evening, that we here are the leaders in the region right here and if we are not going to do something to fix the problem, then it will fall. So we as the coordinators and

administrators, captains, whoever we are, we need to do it, but need to do it now. The boss said it right, corps are dying. And the other corps, the volunteers and partials are picking up the slack and it's very very difficult. We don't get the personnel. We can get funding, we are not getting the personnel and if we don't, we can't answer the call. So right now we need to get the mutual aid going and do a realistic approach, not just to fill up paper, do a realistic approach on what ambulances need to get out to pickup people not getting picked up properly and it has to happen now. Thank you.

MR. PARRISH: Anybody? Dee?

MS. SAGENDORPH: I've been an EMT quite a long time and remember my first EMT class, taught by a very dynamic lady by name of Sue Nickel. You didn't finish a station until you had it right. And I think having worked in the testing areas on EMT and CFR programs and things, what I'm seeing is there is the kids -- the students, not the kids -- the

students are complaining they don't get enough hands-on time for skill. And when we suggested to them they contact -- they go back to their squads and start working with them and get some of the extra time. Because the class is only just so many hours, you can't expect to pay extra instructors, go back to the squad, have them help you. You've got -- most have very talented people, you follow the skill sheet, that's what you do. A lot are complaining there is not enough time. They can't grasp what they have learned in the classroom and then go to the skill station, there is a void someplace. They are not getting it somehow.

MR. PARRISH: And that's what I find with my students, the ones that are successful, they go back to their agency and there is people --

MS. SAGENDORPH: Put in the extra hours.

MR. PARRISH: -- a preceptor. And the ones their agency is, ahhh, you'll get it. They are the ones not making it, the agency is skimming in the game --

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MS. SAGENDORPH: And I think the other thing is, I think the expectations of someone coming as CFR or EMT at volunteer level, okay, you go to a meeting or drill once a month and handle a few calls. But if they are young people they don't have necessarily -- you know -- their lives together. So if they are going to get a chance to go out with their friends, they are going out with the friends, regardless of whether it's their duty night or not. It's hard, you know, you explain when they signed their application, this is what we expect. We expect you to make calls and drills so this is what it is and you have a year in probation, after a year we reevaluate. So many I think are disillusioned, we are not getting three car pileups, not getting cardiac arrests, not the really exciting calls. We get the little lady that fell and may have a fractured hip or the little old man that all of a sudden can't remember where he lives. There is a different type of medicine that we are seeing as volunteers out

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there as well today. You live in an area where you get a lot of auto accidents and a lot of trauma stuff, that's fine, it keeps them busy and active. But if you don't, you have nursing home calls and senior residents calls, it takes away the glimmer, you know, that they are not -- that they didn't sign on for and I think that --

MR. PARRISH: Nick?

MR. TRIO: Yeah, one of the things I find helps me get the younger people involved is to help give them a feeling of actually doing something medical, even if it's going out and looking at all the new things coming down, Narcan, glucometer, CPAP. Getting these things and getting our agency approved seems to be something that gets them interested, saying, well, yeah, there is some real medicine here going on, rather than just I went and picked up to do a lift assist or went to do a fire standby.

MR. BOCKMAN: That and food.

MR. PARRISH: Did you have anything? I guess not. Go ahead, Dave.

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MR VIOLANTE: If it pleases the region, I'm happy as a next step to talk about the Dutchess County task force to see if --

MR. PARRISH: Yeah, Bob?

MR. CUOMO: One thing I just want to bring up, it's very true that our ranks are aging and we need to infuse some young blood into this field.

One of the ways you might want to look into it is in the high schools. Yeah, I know what you are saying, but I'll tell you a story. We have a program going on in Putnam County right now where there has been -- I've sponsored on EMT class in one of the school districts, the Mahopac School District, for the last 10 years. And we have one of the teachers there happens to be a CIC, who is also a paramedic, and he has been running these classes. And it's actually been very good for the recruitment of the EMS agencies that are in that area of that high school.

Matt, you can speak to that because you are a member of one of those agencies, right?

MR. BONDI: Yeah. I think there is -- I

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don't have the number in front of me, but I want to say about 200 EMTs have been created in the last 10 years just to these two agencies from the high school program.

MR. CUOMO: Right, now, how long they stay is another story because that's obviously another problem. But one of the other things we are doing to try and replicate that -- because it's admittedly difficult trying to replicate that in every school district -- it just so happened that we had a fortunate situation where, you know, a person who is already a teacher in the high school happens to be a CIC and the school approved him running the class at the school. You are not going to be able to do that in every individual school district. So what we've done is at -- the Bureau of Emergency Services and myself, I'm actually teaching this class, is that we developed a partnership with Putnam Westchester BOCES and I'm currently teaching a class during the day at BOCES. And because I'm doing it there we are able to reach out to 17 school districts

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and have the high school seniors, obviously you have to be 18, you know, on the month that you are taking your state exam, so your enrollment is limited by that, but we are just starting this, this is the first class. And I have a feeling there is going to be a lot of interest -- at least I hope there is.

That's one way maybe we can start infusing some young people into this, by getting them while they are in high school to get them interested. I think it would be good for, you know, for the volunteer agencies and it might even be good, you know, directing them towards a medical career.

MR. BONDI: All the emergency --

DR. PAPISH: The reason I became a doctor was because a friend of mine left his jacket at his volunteer ambulance corp and I went over and saw a take an EMT class sign, so that's how I started. And there is probably a good majority of you probably started around that age.

MR. CARPICO: I started around then.

MR. CUOMO: Yeah. Yeah. So it's been

good for Mahopac School District. And like I said, Mahopac and Mahopac Falls agencies have gotten a good number of members out of them. I can't say that, you know, that they never have a problem getting out because they do, like everybody else, but I have to say they perform better because they have more members. So this maybe something, you know, to look towards if you can partner with BOCES and try to reach multiple school districts.

MR. PARRISH: So -- yes?

MS. BURNS: This is my evil controversial thing to throw out -- and they gave me a really fast car so I can get on the Thruway and be gone -- one of the things that at the State level -- and it's not just me and the EMS Bureau, but higher up through the Health Department and in -- frankly to the Governor's office -- is that historically, you know, EMS -- we are a very siloed sort of culture. And, you know, I am in the east elbow rescue squad and he is in the west elbow rescue squad and we talk once a year when I cover his banquet and he covers mine.

And this is a big part of your issue with mutual aid too, quite frankly, and what I think -- you know, as charming as I can be -- but one of the things that my job is now is to really sit with at the county level, EMS agencies, and talk with them about improving efficiencies at the local level. And this is the controversial word -- and that may include the consolidation of several EMS agencies into a larger EMS agency. And we have seen it being done and it's working, but it's extremely difficult because we are a territorial animal and we want to wear our own patch and want our ambulance to have our own name and my stripe is red and yours is green. But I think we are at a point in our evolution that we need really to get over that. I'm very fond of saying this, but I seriously believe it in my heart of hearts, and I'm not totally convinced that many of our EMS colleagues -- there is a phrase a friend of mine uses, it's not about us, it's not about you, it's about your patient and your community and if you cannot do the job

you need to look at other options. And a really good option, honestly -- painful I realize -- is really looking at consolidation. It may not be we take three little ambulance services and make them one big one, but rather we take the three ambulance services and develop a singular management service so the services aren't paying for three fax machines, three internet connections, they have the power of buying in more bulk, because instead of answering 200 calls, the umbrella is answering 1,000 calls.

So I just think, as David said, we are operating on a 40 year old way of doing things and we were robust 40 years ago, but most of us are still hanging on by a thread. But I think as awful and difficult as it is, it's bigger than just recruitment. We have to streamline the way we do business because the reimbursement rates are dismal and it costs a lot of money to do business and we can't operate in the same paradigm we did thirty or forty years ago.

And I realize -- again, fast car,

Thruway -- but if you need somebody to come into one of your counties or come to a county meeting, I offered this so that -- you know, Kevin is younger, and he has a ways more until retirement -- but I'm really not afraid to come in and say to the agencies, look, the fact of the matter is, it's not about you. It's about your patient. And we need to really look at this because they don't want to hear it and they can be mad at me. I'd rather them mad at me, than you as the local leaders because I need you to be their resource -- everybody hates the State already.

DR. PAPISH: It parallels health care in general, just look around.

MS. BURNS: It does, look at Westchester. So, again, I applaud the thoughts about education and the recruitment, certainly retention. I think that I'm sick with worry about the future of the change in the minimum wage, which is not to say everybody doesn't deserve a better minimum wage, but it's going to decimate our EMS

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system. I'm very concerned about the aging EMS population because I notice a lot of you have this fine colored hair --

MR. BOCKMAN: Again, you are looking at me --

MS. BURNS: I'm not, you just happen to be in my -- but I think it's -- you know, so it's education, it's people, and it's certainly efficiencies and operation.

MR. PARRISH: All right, a lot of good discussion. The takeaway is we have got work to do. All right and --

MR. TAVORMINA: Motion for adjournment.

MR. PARRISH: -- the folks are here that need to start moving it forward.

There is a motion?

MR. TAVORMINA: Motion.

MR. CARPICO: Second.

MR. PARRISH: Second.

Adjourned, thanks for coming.

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

Yvette Arnold