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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, March 5, 2018, at 9:35 a.m.

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Court Reporter

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ISRAEL KNOBLOCH
SHARON FRAZIER
MICHAEL BIGGS
DAVE VIOLANTE
KEVIN GAGE
DAVE JENSEN
JOHN MAHONEY

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DR. PAPISH: Let get started. Unless we get two more people it will be an informational meeting. Unfortunately, Pam had to emergently go to work so she will be out for the day. I don't think I need a formal roll call, I think I got everybody.

MR. HUGHES: Okay.

DR. PAPISH: As far as -- everybody had a chance to review the minutes on line, old minutes.

So do we want to bring this up? Psychiatric patients and dispositions? Does anybody remember what that -- as far as I thought it was kind of included matter.

MR. HUGHES: Yeah, I think we finished it at the last meeting.

You have to approve the minutes on the record.

DR. LARSEN: We don't have a quorum.

DR. PAPISH: We don't have a quorum. Questions?

MR. BIGGS: Michael from New Windsor Ambulance. A question regarding the psych patients, that was the issue of having a

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formal letter from the REMAC stating that we would go to local facilities and not having to transport everything single patient to Orange Regional or mental health facility unless it's 941 or mental health is requesting that facility. Law enforcement is requesting us to go there all the time for patients that -- or to go to a local facility to be seen first, pediatrics and stuff, we are looking for guidance from the region to have us not have to go to Orange or mental health facility unless it's doctor request or 941.

DR. PAPISH: Was that what the -- and where did we leave off the conversation?

MR. BIGGS: There was going to be a memo in the past that was going to be brought backup again.

DR. VOHRA: I would agree that if a patient needs mental health evaluation there could be a toxidrome going on as well so they should stop at a local facility first and then get clearance because we are pretty much full and we don't have the capacity to handle

pediatrics anyway.

MR. VIOLANTE: Is it something we have to --

(Inaudible.)

DR. VANROEKENS: Two words, closest and most appropriate. Unfortunately, that involves judgment, so hopefully make the best judgment you can. And, again, I think if there is a concern about toxidrome or something then local closest is most appropriate. If it's a clear psych issue and everything seems stable, then it's more of a psych issue. The pediatric issue is a diaster anyway --

DR. RABRICH: Or if you have an unsafe situation, combative, aggravated, whatever, that should go to the closest.

DR. PAPISH: I mean, I speak from a different position. I work at a completely full hospital that has mental health inpatient capacity, but we are always full. And so we essentially operate like any other emergency department until we get a bed up. I think most of the inpatient mental health

facility hospitals are in the same boat.

So the question as to whether a letter needs to be drafted, if people feel that's as much of a problem we could send out an advisory just reminding people of the basic protocol that is in place. I don't know if anything needs to be operationally changed or --

DR. VOHRA: Do all facilities have mobile mental health if they don't have inpatient or psych? Because I know they will go to other facilities like St. Luke's to do consults --

DR. PAPISH: Like Dutchess County has a mobile crisis team that can go to hospitals and do evaluations. I think -- correct me if I'm wrong -- does every hospital have some sort of psychiatric arrangement where they do an eval and then transfer, or do they just transfer?

DR. VANROEKENS: St. Anthony's doesn't, it's a small hospital, it's ED and we are good.

DR. RABRICH: With the advent of all the

larger systems I think there is opportunity in the State for telepsych to take on a larger roll in helping some of the smaller hospitals.

DR. PAPISH: We utilize telepsych in our facility for the night shifts where it's difficult to get a psychiatrist in. I think that's the way of the future.

Well, I mean, sending out a REMAC advisory reminding people of the situation is probably easy to do so we can do that. I don't think there is any harm.

MR. HUGHES: Okay.

DR. PAPISH: Service upgrades?

MR. CRUTCHER: We have a few. For Narcan we have Kent Fire, Brewster, Stony Point, Village of Montgomery PD, City of Kingston PD. For BLS CPAP we have Brewster, Plattekill, Union Vale, Livingston Manor. For glucometry we have Stony Point. BLS twelve week we have Union Vale. And for just PAD applications we have Town of Wallkill and the Zen Mountain Monastery.

DR. PAPISH: That will be for next

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meeting, bummer, it's a lot.

MR. HUGHES: Yeah.

DR. PAPISH: Evaluation subcommittee report? There is no report.

Helicopter? No report.

RTAC? No report.

DR. LARSEN: Um, there was a meeting in February, unfortunately I was not there. The only thing I can report is that there is another RTAC meeting. The next one is scheduled for Friday, May 4th, it's from 10:00 to 12:00 and it's at MidHudson Regional.

DR. PAPISH: And I think --

MR. HUGHES: Do you want to do RTAC?

DR. PAPISH: Were you at the RTAC?

MR. BENENATI: I was.

DR. PAPISH: Anything? I know Dawn Woods, one of the -- I think she's the Quality Trauma Program Manager at Vassar was planning to come today, she may come at the end to talk about the oxygen program, the oxygen research.

MR. BENENATI: There was a significant

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-- I'm pulling up the minutes -- there was significant discussion and retrospective study done for six months in 2017, which identified that there is inadequate oxygenation used in trauma patients in a prehospital setting and the data that they looked at certainly showed that. And Dr. Lombardo is really trying hard to provide some education to the EMS providers to increase oxygenation based on some studies and some papers that they had distributed at the meeting. The challenge that he certainly is meeting is that that is not indicated in the protocol. Protocol currently -- the ALS -- well, I believe the collaborative is driven at 94 percent oxygen saturation and the BLS I think is 92 -- or vice versa, it doesn't matter. I certainly encouraged him to communicate with Dr. Dailey since the protocols are being reviewed at, you know, the State level right now and try to incorporate those changes.

One of the things that, you know, we speak about here at a regional level is maybe

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we can do it as advisory and we are hoping to have some of that discussion going on here. But certainly we are seeing that that -- not enough trauma patients are receiving adequate oxygenation.

I don't know, Dr. Larsen, did you want to -- because that was also discussed at the previous meeting as well, just the findings were confirmed --

DR. RABRICH: I'm still skeptical of this. I would like to see if you want to have this change that the data should be presented to SEMAC. It's not in the protocol, if it wants to be done as pilot there is an avenue for SEMAC to accomplish that.

DR. PAPISH: I don't know the answer and perhaps you guys do, there is obviously ample data to show if somebody is hypoxic and they have a head injury, their outcomes are much worse. But if they're not, just like STEMIs and everything else, are we -- you know, do they have some data -- I have to say I haven't read --

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DR. RABRICH: We all know hypoxia is --

DR. PAPISH: -- what about --

(Everyone is speaking at once.)

DR. RABRICH: -- they don't have a hypoxic event then do they need supplemental oxygen?

MR. BENENATI: So maybe I'll have Karen send out the three studies that they reviewed -- she has everybody's e-mail address. And I tried to get the Power Point and I'm waiting to hear back, we will try and get that to the REMAC so you can look at that data.

DR. PAPISH: That being said, to best of our knowledge it doesn't hurt, so that's --

DR. LARSEN: I think the question --

(Everyone is speaking at once.)

DR. LARSEN: I think the question was at least making sure that the subset of patients that may have a hint of head trauma are going to do better with oxygen based on these studies that have -- large scale studies that have come out of EMS from the southwest. So I think that's what is really pushing this thing and then some anecdotal experience that

Lombardo has had at Westchester Medical Center receiving these patients, in which he's seen problems with the fact that they have not had oxygen and he felt that it affected their neurological outcome. So that's what --

DR. PAPISH: I mean, that's potentially a big issue with bad players and bad care at a local level if somebody needed oxygen and wasn't getting it. But either way this will be interesting to see how it ensues.

MR. BENENATI: And on the topic they discussed -- I believe Dave will talk about later -- is they endorsed the adoption of the MIST reporting format.

DR. PAPISH: We are going to talk about that in a little bit.

MR. BENENATI: Right.

DR. PAPISH: So that is the RTAC.

QI?

MR. CRUTCHER: New York State is still pushing to have the new 3.4.0 bridge up at the end of this month.

Concurrently Image Trend is working a

problem with the current bridge which is causing issue with the electronic data actually being validated. We have had some agencies score a two, which is not possible, so there is an issue with the algorithm they have been working on. They have been processing and actually reprocessing between 10,000 and 18,000 pieces of data a day until they get that up to -- up to par where it should be.

ESO has given us a regional bridge so all agencies that utilize ESO we can see all of their data. There are some interesting reports, canned reports, but still very workable and we are still working on learning how to actually write reports that are going to give us a good overview. That's about it.

MR. VIOLANTE: Without throwing Jeff under the bus -- and I'll help him with this -- maybe we can just do a quick glance through ESO retrospectively and see the number of trauma patients with oxygen and their O2 sat at the local level. At least it will give us a sample we can trend out and

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see if there is anything there from this region as well.

DR. PAPISH: Hopefully the documentation is good at least that would be -- it would be really interesting if it wasn't.

Is that something that is feasible?

MR. CRUTCHER: Yes.

DR. PAPISH: What is -- when you say, you know, some agencies were two --

MR. CRUTCHER: Every field that is a Nemesis required field is given a numerical weight so when a provider finishes a PCR, locks it and gets uploaded, that document is then scanned for this piece of data, this piece of data, this piece of data. What we would like to see is a validation score somewhere between 90 and 100. If it's a PCR that has not been fully completed because it was taken by the first unit there, synced to the next, so the first PCR may not have much data, you are going to see a score of somewhere between 0 and 30, which is okay because they didn't finish it. So when we see a completed document, I can pull it up,

look at it, see it's all there, and it's getting a score of two, that is something not possible and they would notice if they are an agency that bills because they wouldn't be getting paid.

DR. PAPISH: All right, so it will be interesting to see if you can pull that data.

Protocol committee?

MR. BENENATI: I do have a few things.

With regret we have accepted the resignation of Michael Murphy. His work volume and load has become so much he is unable to help us. We want to thank him for his years of service and expansive knowledge and his experiences that he brought to the group.

Following that, if any provider is interested in joining the protocol committee, see Bill Hughes for that.

We also tackled a fairly large topic we need to bring forward. I was hoping Pam would assist us with some of the conversation, but certainly Dr. Papish can.

This is with regards to the advanced EMT

level. This is a fairly confusing matter even to those of us that have been doing it for so many years. And that is because traditionally we have not used advanced EMTs in the region. However, about a year ago here the group approved Hatzolah implementing an AEMT program and so the protocol committee started to tackle how that is all going to integrate into the system. So apparently the first class is now completed -- I understand maybe there are two classes, the first one has completed and they are ready to go on-line. They called the region looking to get the process started and then the protocol committee had to hop into high gear.

So we didn't even previously have a protocol exam for this level provider. So that is in process so that we can begin to get some questions which are appropriate. Certainly we cannot use the paramedic level because not all of the treatment is the same at that level.

We are also looking at how AEMTs operate in different regions. At our last meeting we

conferences in Travis from -- I believe it's Mountain Lakes region -- to talk about how they use them because they use so many of them, so he was able to provide us with some great insight into that. Because when you start to look at the actual protocol then you need to look at the protocol, you need to look at scope of practice, you need to look at what equipment goes with that scope of practice. So do you use an AED, or do you need to use a screen on a monitor because you need to recognize a systole, for instance, or PEA. Looking most likely at requiring ACLS and PALS when you start to look the at the requirements of the protocol certainly we feel that ACLS and PALS are a required component.

In addition to looking at the collaborative protocols we needed to look at the policy documents because there is no reference in any of our policy documents with regards to the AEMT level. So we are doing that also, looking at the minimum level of equipment as I've already alluded to.

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One of the other questions that came up then is, can an agency operate independently at the advance EMT level? So now that we have opened this door will we accept applications for an agency that maybe BLS today that wants to become an AEMT agency? So I don't believe we've addressed that at this group and it's just a piece to look at as we move forward.

And then it is our intention to continue this work, there is a significant amount of work to be done. Like I said, we need to look at every single protocol, we need to look at the supporting documents and we need to get the exam out. It's our intention to bring that back to the REMAC for final adoption at the June 18th meeting.

So I certainly apologize that we didn't have the work done, we really didn't anticipate it was coming forward in this fashion and so we are scrambling to get you guys up and running as quickly as possible.

DR. PAPISH: A lot is really confusing, on the one hand the AEMT level carries AED,

they don't have monitors yet, they're doing intubation and things that require entitle Co2 and cardiac monitoring. So how do you reconcile that with what we are going to do.

So any questions about that? It's sort of a work in progress.

DR. LARSEN: What is the difference between this and the intermediate program?

MR. BENENATI: So that's where you get confused. So these days it really is CFR, EMT basic, advanced EMT, and paramedic. So the old level ones and two are no longer there and the critical care is no longer there. So this falls between a basic and a paramedic is what it does. And it really is a great level for lots of parts of the State, it certainly is going to supplement getting care out there especially for agencies that can't necessarily maintain paramedic standards these days. So it's just figuring out how it's going to integrate into the system.

DR. RABRICH: These changes were all made to conform with the national scope

practice model, there is no CC, it's all -- so now we are consistent with everyone else.

DR. PAPISH: Right, we are still figuring it out.

MR. VIOLANTE: -- different regions do things a little different --

(Inaudible.)

MR. VIOLANTE: -- some regions found that it was really a necessity and so out of that component brought that in training wise, equipment wise and protocol wise as well. So that's where this group is like wait -- what? And there is a lot of work to do so it's --

DR. RABRICH: It sounds like it's kind of undefined so far for the region.

MR. BENENATI: It is, especially for the airway. So we need to actually look at the teaching curriculum to see if intubation was even taught, if not, we'll have to use a supraglottic airway.

And so that's where this has been a challenge, the protocol committee didn't get notified until there was a request for the exam. So we are continuing to work on it and

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we promise we will keep it moving forward with the intention of getting it to this body in June for resolution and adoption.

DR. PAPISH: When you think about it from airway perspective the easy answer is if they don't intubate it makes the protocols a lot easier to reconcile. The patients that they would be intubating most likely are cardiac arrest patients because they're not doing RSI and they're not doing sedation, facilitated intubation at all. And so -- and the cardiac arrest patients do they benefit from getting intubated? I think the answer is no.

So that being said, we will figure out what we're going to do.

DR. RABRICH: Right, you guys have to decide what you want to do, but the literature says they should be doing supraglottic airways and not intubating.

DR. PAPISH: So that is RTAC -- that is protocol committee.

New business?

DR. LARSEN: So under new business I

would like to introduce this, I've been involved with American Heart Association American Stroke Association, some of the folks here have too, and, you know, as things have progressed what is key is first patient contact to getting definitive treatment and whether that's going to be, you know, PCI center for STEMI, or that's going to be a comprehensive stroke center for stroke. But anyway, they are trying to expedite this and so they have come up with this STEMI Reperfusion Decision Tree For Referral Center. So this is basically a plan to move patients rapidly through the system. So whether they first present to -- when they first present to a nonPCI center.

So EMS is intimately involved in this because they are going to be part of this transfer piece. And what they want to try and do is go through this and simplify it so that everyone operates -- all hospitals in the area sort of operate on the same ideas and protocols whether you are receiving center or sending center, that you sort of

ramp up the patient in the same way, prepare them for rapid transport. We tried to make this as simple as possible, all these types of things. And so that's what this algorithm that I have, which was handed out, the STEMI protocol for patients self-presenting to STEMI referral center, so that's for the patient who walks in there. Okay?

There is also the question of EMS being dispatched for -- you know, an ambulance arriving at the scene and picking up the patient too. But this is the -- basically a referral system from what they are calling referral centers, so these are nonPCI center.

So I think that people should definitely look through these, we certainly can't vote on anything today, but I would like to try to formalize this more perhaps in our next meeting in June.

And what they are showing here is there is basically a three page document including a transfer form, okay, and just sort of a basic outline of what is expected at each level along the way in the ER --

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DR. RABRICH: Just I haven't looked at this detailed yet, but some of the goal time frames seem somewhat unrealistic given current -- for instance IFT notification to ambulance arrival of less than 10 minutes, that's going to be a challenge for a large part of the region, particularly on off hours. We are lucky we can get them in 20 minutes. And so triage to EKG, so I know it --

(Inaudible.)

DR. RABRICH: -- then five minutes is also a very short time given all the EKGs we do. So I think this is great, I jut think there is some unanswered questions still what can we do realistically.

DR. LARSEN: Right, I agree. I've raised some of these questions. I would definitely urge people to become part of this and, you know, get -- primarily we meet every once in a while, but primarily we are meeting on the phone in conference calls. In fact, there is a conference call tomorrow at -- I think it's 3:00 o'clock -- discussing this.

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So anyway, but this is the goal and this is what American Heart Association, American Stroke Association is moving towards and not only here, but on a nationwide basis. I think they are attempting to figure out what the road blocks are and how to implement it and this is what they are talking about. So we need to participate in this conversation because it intimately involves EMS and the prehospital package and certainly, you know, they understand an attempt to try and make this also fair for both referral hospitals and PCI centers. But to achieve this goal of getting people as rapid care as they can --

DR. RABRICH: Right --

DR. LARSEN: -- that determines the outcome.

DR. RABRICH: -- I think one of the things we have to discuss too, which some places have done -- is treat the STEMI transfer as a 9-1-1 call. And send -- because you know you are not going to get the transport in sometime in that time frame so some regions have chosen to, you know, treat

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this as a 9-1-1 call and dispatch actual 9-1-1 ALS unit.

DR. PAPISH: That's happened periodically in our region. I know of a couple instances at a couple different facilities --

DR. RABRICH: Right, I think that's a discussion we will have to have.

DR. PAPISH: The local EMS units loved it.

DR. RABRICH: Right.

DR. VOHRA: -- we are measuring that not just door to balloon time but to medical contact.

DR. RABRICH: Yeah, you know, door in door out of 30 minutes is tough.

DR. LARSEN: American Heart Association is starting to hand out these little awards for all this kind of stuff. So -- and again, they are also -- excuse me?

DR. PAPISH: First, it's the awards then it's the financial benefits --

(Everyone is speaking at once.)

DR. RABRICH: -- the first year then we

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are going to penalize you.

DR. LARSEN: Anyway, especially with some of the new data that has come out around stroke and interventional stroke, I think that will change radically too in terms of how we handle stroke patients in the field and transferring, the same pressures will be on us to figure out how we move these patients through the system.

So anyway, like I said, you know, this is the first time we are really sort of discussing it in a group, but I think this is really big time is our issue. You know, whatever you work out in your hospitals and however you compress things in your hospital, that is another thing and certainly the PCI centers are going to want and interventional stroke centers are going to want to compress their protocols and all that, but our piece is still our piece. And that is first basic contact until somebody hits some type of medical facility and how do we do that? And then once they hit that medical facility how do we work that transfer piece?

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So I would like to -- I think this is somewhat of a priority, we should try and at least look at some of this material. I urge people to get on the Mission Lifeline stuff. You are certainly welcome to contact me. I can distribute the phone call -- the conference call and all that kind of stuff and then hopefully discuss this in June.

MR. VIOLANTE: Yeah, as a public health systems guy I think this is fantastic stuff. It's patient centered, it's effective, efficient, all those kinds of things that are part of it. When you guys have the discussions about how to get the ambulance there and dispatch as a 9-1-1 call I urge you to have the discussion with these agencies that work with you because there is places now that don't get ambulances for a patient's home. And so, you know, if the person is in the ED that's better -- it's more care than some people are getting at the moment. So just to have that discussion with those services to work that out would be great.

DR. PAPISH: Is there any component of

this that we would change our operating procedures? You know, like when we talk about at the June meeting -- I mean is it more notifications of goals, or is it significant operational changes that we would be --

DR. LARSEN: I think it would be certainly a guideline we'd like to try to achieve and endorse. But I think, like you said, the conversation of how you get an ambulance in 10 minutes, those kinds of things, we need to -- that kind of stuff we need to talk about and figure out how we can do it without putting undue burden on people and so on, but still try and push it forward.

DR. PAPISH: All right, one more item that we didn't talk about really to the protocol committee was our -- the regional EMS radio report. So I believe we talked about this at the last meeting -- I guess it's not under old business. But we were trying to work on a uniform method of giving a notification that would be concise, accurate, and not containing a lot of

extraneous information, but at the same time giving everything that people needed. And I think we recognize that most people that have been doing this a while are giving their notifications the same way regardless, but that being said, if we came up with a template that we would endorse it would be useful to providers in the region that A., weren't used to giving reports, and B., were transporting specialty care to various hospitals and what information they needed to relay. So we sort of came up with an amalgamation of the MIST report and -- where did the second one -- was that just drawn up in RTAC?

MR. VIOLANTE: We had some information from the protocol committee. We canvassed the hospitals, saw what they wanted to get, trauma reports, STEMI reports, stroke reports we canvassed EMS providers at a couple of the conferences that are around and looked at all and said just mush it altogether and it sort of really fit into the MIST criteria. We just wanted to expand in a couple areas,

which is some of the pieces on the bottom as considerations and it really sort of all fits.

DR. PAPISH: So this is what we came up with if you guys look through it. We are not really voting today anyway about endorsing anything, but it seems like it's a reasonable approach to, you know, laminate and put out there so people can have it as a template in the back of their rig --

DR. RABRICH: We moved at Nyack to electronic notification, there is a product for that and it's templated that way. And we can -- the company will adjust template so it fits this format even more and you are getting a standardized electronic report, so that's one to ensure they hit all the points is the little tiles to tap --

DR. PAPISH: -- that maybe coming up here too.

DR. LARSEN: Yeah, it's happening.

DR. PAPISH: Any other new business?

MR. VIOLANTE: Yeah, I have one thing also. This sort of goes along, Erik, with

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what you were saying.

We are diligently working to get electronic versions of PCR into the hospital systems, into hospital reporting, especially with the idea of Mission Lifeline component of systems of care, which includes prehospital components and a lot of STEMI, trauma, stroke reporting component end up wanting to know when is the first initial care, you know prehospital providers, incorporation of prehospital providers in the system. This particular way we have a good way of getting any kind of electronic report into the hospital system through one of the vendors, ESO, we are working with two major hospital systems at the moment. It looks like it's going to happen after -- I think this has been eight years we have been working on this. And so just some of the components right now are from the hospital perspective for compliance is getting data back out to prehospital providers. We have got a number of rules, laws, regulations that advocate and say that that information needs

to come back to us and so we are working with those systems to make it happen. Part of it is QA QI process and part is through reporting through these particular components, STEMI, trauma, stroke, et cetera. The more this happens and gets incorporated, the better it is for these systems as well of getting the data and being able to work with what is happening data wise with the single patient. And then also really dramatically improving prehospital care so that we know now what actually happened to a patient. At the moment we have absolutely no idea unless we know of someone that that was a STEMI, the person is on the floor getting a cath right now. We don't know that information at the moment, that will dramatically help in the QA QI and educational process.

One of the things we found is we need the help of this body to do it, to be able to get that data back out. So medical directors, the REMAC, this is tremendously important for those hospital systems to hear that we need this data for you and for us.

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So we may actually get or probably ask for a letter from the region, from the medical director and individual hospital medical directors that this needs to happen at that level.

DR. PAPISH: Do you know, does ESO have a list of people that are or organizations that are working with -- that have done this? Because I think what probably is -- would be most useful -- I know at my organization they are very -- compliance is very resistant to releasing anything. And really it's a face sheet and diagnosis, which I think pretty much you all -- most of the organizations in this country agree that EMS is a HIPAA partner, whether it's explicitly written or not. So it really doesn't seem like it's a compliance issue, but one thing I think would be useful in helping to convince organizations are a list of hospital systems that are doing it currently. My guess is out west there is probably thousands of them. And if you could say there is five hospitals that are all doing this, it's not a giant

violation, it may help.

MR. VIOLANTE: The further you get away from the northeast the more this is happening -- or has happened, some systems have been doing this already for 18 years. So that group does have available to us a list of hospitals and has offered their attorneys and compliance and legal departments are very willing to discuss that with any hospital here that is interested in incorporating this.

DR. LARSEN: I think one thing that may change and push the hospitals, if like again, American Heart Association is going to hand out these little awards, one of the things that you have to do is you have to inform EMS of your STEMIs within two days as to what the outcome was. That is a -- that is a hoop that you have to jump through. If you do not you can be the best STEMI center in the world and you are not going to get the prize.

MR. VIOLANTE: So just as a timeframe, as soon as a paramedic or EMT finishes their report, within 20 minutes your hospital will

have it in their system to view by you. And then any time you attach something to it, it's based on the hospital system, that stuff goes back only to the providers on that call, it's not for a huge patient information, it's not anything big. And it's up to the hospital what the providers can get, but that timeframe can happen very very quickly.

MR. JENSEN: If I could add, the feedback that comes back to the provider, as soon as the ED clinician signs his document that has the diagnosis on it that diagnosis rolls back through outcome feedback to the provider.

MR. VIOLANTE: So it's fairly quickly --

MR. JENSEN: It's automatic, it doesn't take a key stroke.

DR. PAPISH: I think it's very useful. And, you know, hopefully going forward we will be able to get it across the region.

DR. LARSEN: Just along those lines, we -- at my hospital in White Plains we have really worked with all the EMS agencies and are now getting about 90 percent of all the

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PCRs are actually making it into the patient record. We are also making our docs actually sign the PCR if -- you know, and just we are just looking at it, we are having them sign it and time it when it gets handed to them. The clerks are handing them the PCR as they are coming in. I mean, we are getting them by fax so -- and the clerk is our ER clerks are basically monitoring the fax machine, when the report comes in they bring that to the doc, hopefully the patient is still there and the doc is having to sign off and time. So the idea is that, hey, you know, these are valuable pieces of paper that add to the care of this patient, you should be looking at it. And just even just trying to get -- so you either sign this piece of paper or at least you make sure you talk to those medics and EMTs when they come to the door.

DR. PAPISH: Given the option, you know, the average physician would rather talk, which is, you know, much better.

DR. LARSEN: Absolutely.

DR. PAPISH: That's great.

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Other new business?

SEMAC?

Is there -- Mike, do you know any SEMAC --

DR. RABRICH: SEMSCO didn't have a quorum last time so we didn't have a meeting.

MR. BENENATI: Obviously a bunch of things were announced. The collaborative protocols is on hold until the May meeting, they're awaiting information back -- actually they have information back from the TAC and EMS For Children. Also, they intend to go forward with the BLS protocols in getting that adopted based on that information. Minor changes being made to the collaboratives.

And other than that, not much else really to report -- next meeting is May.

DR. PAPISH: Okay, Jeff, PAD, EpiPen, albuterol?

MR. CRUTCHER: I already gave you those.

DR. PAPISH: Hopefully we will be able to vote on those next meeting.

Open forum?

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DR. LARSEN: I have one item. On Friday March 30th is Stop the Bleed day, you know, as part of this nationwide -- I guess the Hartford initiative. So you know, we've actually ordered some models and are training up some folks and are going to try and start doing some community outreach with this program. It's just one more thing to sort of add to our long list of stuff to do, but I think it's a pretty good program in terms of putting it out there, just like CPR. So anyway they have an official day for it now so --

DR. PAPISH: Yeah. Who approves official days? How does that work?

DR. RABRICH: Just make one up on your own --

DR. PAPISH: I see some days I'll put out, just know they are --

MS. FRAZIER: Sharon Frazier from MidHudson Regional we have been -- MidHudson Westchester -- probably doing stuff for training for four or five months. We do have something coming up for the date -- the

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31st -- it's actually a Saturday, the 31st is national day. It's a bad weekend, but it is what it is.

DR. RABRICH: Easter weekend.

DR. PAPISH: How about that for timing? We were just on open forum. So do you want to talk about the oxygen that -- we were discussing this earlier. The question was what the outreach program is going to be.

Introduce yourself.

MS. WATKINS: Dawn Watkins, I'm the trauma program manager at Vassar. We are part of the Hudson Valley Region advisory committee and we are trying to do the PI project for our region for trauma patients for prehospital oxygen.

So essentially we are working with Westchester, we are -- found -- actually all of the trauma centers in the Hudson Valley we found that a lot of patients are coming with no oxygen and they are either requiring blood product, MTPs, they have solid organ injuries, especially traumatic brain injury and they are not coming in with any oxygen.

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So we are pushing for oxygen to be given to all trauma patients regardless of mechanism.

DR. PAPISH: Now, this is just an outreach, like a study, or is there an actual outreach program hospital to hospital?

MS. WATKINS: There is the thing called the Epic study in Arizona where it shows -- it's evidence -- evidence practice in prehospital care, it's for TBI and for oxygen and hypotension. So we are taking parts of that study and trying to make a research study for the region with Westchester to include -- but we don't have any outcomes yet so right now we are in --

DR. PAPISH: Discovery mode.

MS. WATKINS: Yeah. So we went through the first six months of last year for data from all the hospitals about whether or not they came in with oxygen and what their outcomes were. But that will be our next step and we are presenting this to the STAC in May so.

DR. PAPISH: Is there -- one of the things we were discussing earlier, without

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having read any of the studies is there any data that you know of that supports giving oxygen or showing that patients that have normal oxygenation have worse outcomes?

MS. WATKINS: So especially for traumatic brain injury the study is one episode of hypoxia and one of hypotension quadruples your chance of mortality. The other patients with like solid organ injury, TBI especially, and if they require blood product in the first 24 hours, you don't know that from the field. So even patients falling from ladders any -- you know, not a single level fall, but any fall from a height, they are not coming in with oxygen. And the EMS providers are saying, well, we didn't think they could have a head injury, but obviously you always want to suspect that.

DR. RABRICH: I think what you are advocating is give all trauma patients oxygen. However, I don't think there is evidence that supports -- I think it's worth studying, but I think it should be presented

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after the STAC and SEMAC because currently EMS protocol does not say give everyone oxygen and frankly I don't think we know if all --

MS. WATKINS: The problem is --

DR. RABRICH: -- approach it as a pilot product for the region that's approved by the SEMAC.

MS. WATKINS: I agree. The patient with TBI, unless they have CAT scan in the ambulance bay they don't know if that patient -- even with suspected head injury they are not getting oxygen, so obviously you are not going to know if you are a solid organ injury or bleeding, other than if you have like a seatbelt --

DR. PAPISH: But the protocol -- currently our protocol says if somebody is hypoxic they should receive regardless. So the caveat of patients that have head tram that is hypoxic, which is the group that we are supposed to be obviously preventing from having a single episode of hypoxia, the protocol still demands that that patient get

put on oxygen. I mean, I think one of the problems we have maybe just the misinterpretation of -- or just bad practice among some players that they are not coming in on oxygen, even though it's indicated by the protocols, which is more of something of an educational outreach, would be something we have to correct --

DR. RABRICH: To me the question is, like you are saying, what is the data and is it unrecognized hypoxia that is causing this? In other words, if I have you on an pulse ox monitor and you are not hypoxic and don't become hypoxic is that the same as giving you oxygen? I don't think we know the answer to that. So is it a bad practice like he's saying in that people are having episodes of hypoxia that aren't being recognized by EMS --

MS. WATKINS: I don't think that's the case. What I heard from EMS providers is they will put oxygen on a patient and the ER docs or nurses will say, why did you put oxygen on? But from a trauma standpoint all

of those patients should have oxygen. For outcomes -- those patients not necessarily are hypoxic, so -- but you don't know what -- you don't know what you don't know, you don't know what the injuries are. So I think that for the small time period that you are transporting those patients oxygen is not going to be harmful in anyway. But the possibly they could become hypoxic is harmful --

DR. RABRICH: Well, I don't know. It needs to be studied, you are making a lot of assumptions --

MS. WATKINS: -- there is a study that says oxygen is bad and I think once that study came out a lot of EMS providers stopped providing -- giving oxygen. The caveat in there is in that one study -- I wish I could pull it up for you -- but it said with trauma patients the small percentage -- the small amount of time you are giving that oxygen to the hospital is not harmful. So it is something that we are trying to study, this is why it's a big push for the region so --

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DR. PAPISH: I don't think we are really -- we are playing devil's advocate in the interest of trying to discover, but I think we want -- I think the RTAC -- the plan would be to figure out what is right overtime. So is there any kind of -- you know, so this is good information, is there anything that is coming down the pipeline as far as we are going to hear or want to --

MS. WATKINS: Well, I think Dr. Lombardo is trying to push for like some changes in ALS protocol, but BLS protocol is what I used in my presentation. It just says that oxygen delivery is up to the provider and if they're less than 92 percent you can give oxygen, but even that is not good oxygenation so --

DR. PAPISH: So -- so I guess the question is it has to --

DR. RABRICH: Go to SEMAC.

DR. PAPISH: -- and SEMSCO.

DR. RABRICH: I think it would be helpful if you guys could make a small presentation to this body or share the literature that you are basing this is on so

everyone kind of has the same frame of reference to help you with this.

MS. WATKINS: Right, I presented at the last RTAC a presentation that was all the data that we have taken for the first six months of 2017 with the evidence that we have collected from the research article so I can present that here if you --

DR. PAPISH: That would be great. But I guess really like this is going up the ladder to the state because --

DR. RABRICH: I think it has to --

MS. WATKINS: So we will -- I'll present it May -- I believe, it's May 4th -- I'm not sure of the date -- or something like that, at STAC so we will go through, that's just the advisory committee so it's not --

DR. RABRICH: STAC is great, but to make a change in EMS it has to go to the SEMAC, which is May 15th and 16th.

MR. JENSEN: I believe Dr. Arshad and Dailey have also had a conversation on this so it's working --

DR. RABRICH: It's way through there, so

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-- right, because our providers are going to say it's not what the protocol says, so we have to --

MR. JENSEN: And that was a discussion we had at the RTAC that was very lengthy.

DR. PAPISH: And we endorse the collaborative protocols, which is -- it's not worth going into all that.

Any other questions on that?

MR. KNOBLOCH: If we are transporting ALS to the hospital so we have pulse ox the whole way and patient's oxygen saturation is 97, 98, 99, do you still advocate?

MS. WATKINS: I'm still advocating for especially a patient with a head injury.

MR. KNOBLOCH: You would say nasal --

MS. WATKINS: So the evidence is either six liters nasal or nonrebreather.

MR. KNOBLOCH: I don't think it's against our protocol to give them oxygen --

DR. PAPISH: No, it's not against the protocol, but it's not required currently by the protocol. And so really the question is -- or, you know, are they going to come up

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with convincing evidence that says that protocol should be changed? And we will see what happens.

In the meantime I think everybody is utilizing appropriate medical judgment and until that changes there is nothing else you can do.

Other new business?

Open forum?

Motion to adjourn?

DR. LARSEN: We don't need one.

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

Yvette Arnold