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

Yvette Arnold,

Court Reporter

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

DR. PAMELA MURPHY,
Committee Chair

DR. MARK PAPISH,
Medical Director

DR. ARSHAD,
Evaluation Subcommittee Chair

WILLIAM HUGHES, EMT
HVREMSCO Executive Director

JEFFREY CRUTCHER,
QI Coordinator

BON SECOURS COMMUNITY HOSPITAL

DR. CRAIG VANROEKENS,
Director

CATSKILL REGIONAL MEDICAL CENTER

DR. VOHRA,
Physician Representative

GOOD SAMARITAN HOSPITAL

DR. DENNIS MAO,
Director

HUDSON VALLEY HOSPITAL

DR. GELLAR,
Physician Representative

ORANGE REGIONAL MEDICAL CENTER

DR. ROANTREE,
Physician Representative

PUTNAM HOSPITAL CENTER

DR. BUTTERFASS,
Director

MID HUDSON REGIONAL HOSPITAL OF WMC

DR. PAPISH,
Director

DR. ISAAC BRUCK,
Physician Representative

VASSAR BROTHERS MEDICAL CENTER

DR. ARSHAD,
Physician Representative

WESTCHESTER REMAC LIAISON

DR. ERIK LARSEN,
Physician Representative

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

DAVID VIOLANTE
MIKE BENENATI
ANDY LAMARCA
NELSON MACHADO
RICHARD PARRISH
ISRAEL KNOBLOCH
ERNIE STONICK
MATT NOLAN
SHARON FRAZIER
TIM MURPHY
JOE SOLDA
TAFFORD J. OLTZ
DESIREE LEONE-STOLL
GUY CARPICO
KEVIN GAGE
DAVID GRASS
KATHRYN MININI

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DR. MURPHY: Let's bring the meeting to order. Sorry, I was so late, it's just one of those days --

DR. PAPISH: I think you were less than a minute late.

DR. MURPHY: I know, but I'm usually here. So this morning I just want to thank everybody for coming and do you want to do a roll call -- just note their appearances.

And his appearance he just got here.

(Dr. Erik Larsen entered the meeting.)

DR. MURPHY: Good morning. So reviewing the minutes of the January 9th meeting, they were sent out electronically -- we are trying to save trees.

Any additions, deletions, corrections? And if not I'll ask for an approval.

DR. MAO: Motion to approve.

DR. MURPHY: Thank you, Dennis. Anyone else?

DR. VOHRA: Second.

DR. MURPHY: Thank you -- near and dear to my heart -- thank you.

Under old business, we finally have the

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final 2016 collaborative protocols final version. Except one thing -- Michael, what was the final thing with the oral decadron? There was so many conversations --

MR. VIOLANTE: There were a lot of conversations about that, yeah.

DR. PAPISH: The conclusion was 10 milligrams IV doesn't matter --

(Everyone is speaking at once.)

MR. BENENATI: But I haven't seen anything final released, I've seen a summary but no release --

MR. LAMARCA: Just decision --

DR. MURPHY: Maybe I'm missing something, but I think it's silly that we would make people carry tablets or -- I don't know -- anyway, so we will see what happens. It was a discussion of the pediatric people on the collaborative protocols, so yeah you are not going to get a kid to take a decadron tablet and so we talked about having UTI take it orally and so we were going back and forth about adding it onto the protocol that way in the -- in our pharmacological armamentarium.

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And so it was back and forth because some people said, why would you even want to give decadron prehospital because they are so close to the institutions, whereas other people in other remote areas would like to have it because they are further away. So to make it all work we will probably be just adding both types, but I'll keep you on the update.

So they are finally done and, Mike, what did we decide on the date? April 1st -- April 15th, tax day --

MR. BENENATI: April 15th. Approval and training to begin so that everybody is done, provided you need to be on-line by April 15th, or their privileges would be suspended.

DR. MURPHY: He is very rough this morning.

MR. BENENATI: Well, that's what we agreed upon --

DR. MURPHY: No, I'm kidding. We were discussing it, I understand. But I think that they are pretty similar and we

highlighted some of the differences, but we have to have a final vote.

Do I have enough people?

MR. HUGHES: Yes.

DR. MURPHY: Great, so I have a quorum. So what I would like to do is have an official final vote. So it's the final draft, again, from the last time you saw them the only differences were really just clarifications and we had a few typos in there that no matter how many times we look at it you always find another one.

MR. LAMARCA: You want to discuss the process too?

DR. MURPHY: Oh, yeah. Let's first vote and then -- or should we do the process first?

MR. VIOLANTE: Are you voting on protocols or process?

DR. MURPHY: Protocols.

So can I have a motion, Mr. Benenati?

MR. BENENATI: I can't --

DR. VANROEKENS: So moved.

DR. MURPHY: Second?

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DR. VOHRA: Second.

DR. MURPHY: There we go.

So process, go ahead.

MR. BENENATI: So the process would be that if the training were conducted as part and through the agency, through an agency approved instructor, we broke this down and the training materials are released and they are fantastic. One of the things that we did though is because there were so much of them, we broke them down as required training and then recommended training. If the agency conducts all of the required and recommended training through links that they will be provided, a provider would receive three hours of medical control contact hours for that because all of the presentations really are physician driven. That is not required, but therefore if they did less than that and if it was nonsupervised they would get no medical control contact hours or broken down.

Following that there is an exam that is on-line that Jeff has setup that each provider would need to go on and take. And

they would actually initially only get one chance to take it. After that they have to recontact their agency and then the agency would contact Jeff to have it reset so they could take it again. The exam would be through -- you know, done through a phone, laptop, tablet, or whatever and it's open book as well.

And then -- we already indicated it would be the 15th. A REMO credentialed provider just needs to take the exam. If they want medical control contact hours they need to do it through the entire process.

We were going to allow for reciprocity. The person from the Westchester region, they have to do the same as us so then it's simple reciprocity you just simply --

DR. MURPHY: Yeah, the only reason we did that, REMO wasn't having an exam. We felt the only way to get people to look at it and open it up, it's a very simple formatted exam with a test bank on-line as Michael said.

MR. BENENATI: Is Westchester going to

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reciprocate with us?

DR. LARSEN: Yes.

MR. BENENATI: So that makes sense, this makes it seamless for those providers. The only thing still being worked on is we had pulled out the -- well, we didn't, the collaborative pulled out the policies that really are behind the protocols and they need to be thrown into our policy manual. And that work is still being done and we will release that as soon as possible. But that still needs to be just done and that is stuff like communications failure, emergency incident rehab, transfer of care, specific stuff to our region. And that's all I have.

DR. MURPHY: And --

MR. VIOLANTE: Also the app is up-to-date and out now as well.

DR. MURPHY: Did we get the Android one? Because that was the one that was slower than iPhone.

MR. BENENATI: It was my understanding both were done.

DR. MURPHY: Because the last meeting --

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MR. BENENATI: I don't see that got forced down into the field so I believe they are going to have to get it. Initially it was believed it was going to be forced to providers, but I don't think it was. I think you have to go get it.

DR. MURPHY: Okay. And I think -- oh, the other thing was, remember, anybody that had the iPhone app from prior don't we have to reload --

MR. BENENATI: That's what I was saying, reload it.

DR. MURPHY: The whole thing, not just an update?

MR. BENENATI: That's even possible too, yeah.

DR. MURPHY: Okay, thank you. So --

DR. ARSHAD: What is the title of the app?

DR. MURPHY: New York State collaborative protocols --

MR. BENENATI: It looks a little different. I saw somebody in the Google the other day, but not in the Apple one. We did

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NYS collaboratives and it popped up.

DR. MURPHY: Make sure when -- it has Hudson Valley when you open it up on top. Since we were one of the original six we had to drop off and they had to reload us so everyone now can have it.

DR. ARSHAD: I'm done loading it now -- but are there any Android users?

DR. PAPISH: No, iPhone.

DR. MURPHY: Android was the only thing we had a problem with initially.

DR. ARSHAD: Just for guidance, are there any Android users in the room? Wow, buy Apple stock.

DR. LARSEN: So what are you going to do about the medical control physicians?

DR. MURPHY: Oh, how to get them on board?

DR. LARSEN: Yeah.

DR. MURPHY: We send out the exam and everything to the director of the department and ask them to get their docs to do it and send it back and just sign off.

DR. LARSEN: They are just going to do

the complete same test?

DR. MURPHY: Yeah. What did we say about that? We didn't say for the provider, we didn't discuss that --

MR. BENENATI: We did not.

DR. MURPHY: The last time we did the same exam, open book again. This one we are doing a very short one, not like the full exam you take when you are a new provider. But we will just have to do the short one for the docs too.

MR. BENENATI: The discussion was that we would send -- we are going to send a package electronically that has all of the links of all the training programs and including the test so they can either watch the videos, or choose to go straight to the exam and take the exam on-line then because they will get the same packet going out to all the agencies.

DR. LARSEN: And all medical control physicians will have to do that entire test?

MR. BENENATI: Yeah, but the test is what -- 15 questions?

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MR. CRUTCHER: Twenty-five.

DR. LARSEN: So we can set our policy.

DR. MURPHY: And what we did is take all of the videos and we selected out ones that we thought were mandatory that people really needed -- or required we called it.

MR. BENENATI: Required and recommended --

DR. MURPHY: -- recommended and so what we did was pick out the ones we felt really hit across the bow of what we do on a day to day basis. And so then the other ones -- that were excellent, by the way. Again, thank you, Dr. Arshad and Dr. Fullagar. We let those be recommended just because we didn't want to -- we said -- how many hours was it? Three hours?

MR. BENENATI: Three hours medical control contact hours.

DR. MURPHY: Just the recommended videos and it was a lot actually.

MR. BENENATI: The three hours included required and recommended.

DR. MURPHY: Okay, I thought it was four

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hours. So that's what we had them do and this way it's both on an educational purpose and by providing medical control contact hours gets people incentive to do it for sure.

Okay, any other comments?

MR. NOLAN: On the app Orange Regional is not listed as a trauma center and you can still bring strokes to Cornwall.

MR. BENENATI: So is that the Android?

MR. NOLAN: Apple.

MR. BENENATI: Also, Dr. Arshad, make sure you check, when Andy just downloaded it it appears he grabbed the 2015 version so be careful you have the newest one.

DR. ARSHAD: It says updated protocols are available, please update now to ensure you are using accurate protocols.

MR. BENENATI: Just be very careful with the app.

DR. MURPHY: Yeah, with iPhone, if we had it before we have to redo the whole process, we can't just renew or update it.

DR. PAPISH: There is an update button

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on the current one, if you are up-to-date it says you are up-to-date.

DR. MURPHY: So yours is 2016, make sure --

DR. PAPISH: I think so.

DR. MURPHY: What did you just say? It made me think of something -- did it work, Andy?

MR. BENENATI: So it does not appear the Android is available, it says coming soon.

DR. MURPHY: I didn't think it was. I didn't think they had it ironed out yet --

MR. HUGHES: It was supposed to be March 1st.

DR. MURPHY: Yeah, we will check it.

Okay, thank you.

Under Narcan update? Can you update?

MR. HUGHES: Yes. We have gotten our second order back in stock so we do have some available. Immediately upon getting it we shipped out most of it from back orders that we had. And we have requested another shipment, so we actually doubled the shipment we have coming in so hopefully within the

next couple weeks we will have plenty of Narcan available, but we are still going through it quite quickly.

MR. BENENATI: Point of order, you got a motion and second. You did not vote.

DR. MURPHY: Sorry -- sorry, I didn't. Oh, gosh, sorry. I'm totally -- I should have stayed in bed.

All those in favor raise your hands.

So it is unanimous, thank you. Thank you, point of order.

MR. BENENATI: I'll be here the rest of the meeting.

DR. MURPHY: Thank God you said that because he would be elbowing me later.

DR. ARSHAD: Quick question, which videos did the committee select as mandatory?

MR. VIOLANTE: Everything that you were in --

MR. BENENATI: So required is comparison 2015 to 2017 --

DR. MURPHY: The little overview.

MR. BENENATI: -- Dr. Dailey's. The critical patient resuscitation, the patella,

the double sequential defibrillation, the surgical airway bougie assisted, the eye irrigation, the dental emergencies, and the manage agitated patients, ketamine for the agencies that carry ketamine.

DR. MURPHY: For ketamine -- just the last one -- but because the patella and tooth, we had to put those on there because we technically had them like -- well, up for grabs and patella is new, even though most physicians in the room were fine with it we wanted the providers to have --

MR. LAMARCA: We had the two issues about RSI and ketamine about agencies that specifically were using that --

DR. MURPHY: Yeah, but remember, the airway one was good because it could show people how to assist and to be there and do everything else, yeah.

Okay, hospital diversion. So we were supposed to make a TAG I thought, right?

MR. BENENATI: Actually, Jeff has the work -- it was discussed at the protocol committee and Jeff was going to pull that

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altogether.

MR. CRUTCHER: Yep, pretty much done.

MR. BENENATI: So we will bring that to the next REMAC.

MR. CRUTCHER: Yes.

MR. BENENATI: It's using the system already implemented. Dr. Papish did a lot of research and a lot of work on it --

DR. PAPISH: Yeah, it's already in place. Westchester County has a system that incorporates all the Hudson Valley Regional hospitals and is able to delineate via web browser who is on and off diversion, tabulate reports and it's a very -- mechanism for us to follow. Any hospital not using it just needs to contact them and we will send an e-mail with the information just to -- how to get their account. So all you have to do to go on diversion is click on it and everybody can see -- I think it puts you automatically off for I think six hours --

DR. LARSEN: Fours hours.

DR. PAPISH: -- four hours. And when you are off diversion you can go off

diversion. This way we would be able -- the issue was we couldn't -- we had no really good data on the problem so it provides an easy means to track the data and also provides a means for all agencies really, including dispatch, to pull-up the provider and see who is on diversion.

DR. LARSEN: Just one note is that Westchester eliminated diversion, you know, except for -- you know -- equipment failure, hospital failure, emergency department failure, CT failure, special interventional cardiology failure, those types of things. But the old diversion as we know it and used it most commonly, which was because things were too busy in the ER, has been eliminated so for Westchester --

DR. VOHRA: Orange will be doing the same thing effective April 1st.

DR. MURPHY: Since January 16th you had -- you have not had a single diversion day and we only had one day of holds and they were temporarily in the hold, they were gone within two hours.

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MR. LAMARCA: You seem to be taking a personal interest.

DR. MURPHY: I am. Where the rocks were thrown -- no, no, it was totally ownership. And it's really -- I have to give credit to Dr. Vorha with his --

DR. VANROEKENS: Question, one option is to just, you know, declare basically no diversion in the Hudson Valley, that's one option. That's what Westchester ultimately choose with the exception of electrical failure and that kind of thing. The other is to participate in the Westchester tracking, but that's voluntary. How would one enforce that?

DR. PAPISH: I mean, I believe we can stipulate that if you want to go on diversion, that's the process to go on diversion. So it would make it a requirement and then if hospitals are not doing that and dispatch centers are not receiving information they are on diversion we know they are not putting themselves on the tracker.

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DR. VANROEKENS: Would that be a motion?

DR. MURPHY: We can make it a recommendation that comes from this committee if everybody is in favor. I think that -- I think most people are on it. When I saw the papers you already sent out it seemed like everybody --

DR. PAPISH: It's just whether people know, they have a login, everybody has it, but if they are using it --

DR. VANROEKENS: But there is no requirement for reporting for the hospitals aside from emergency departments that we want to require this.

DR. MURPHY: Do you want to make a motion?

MR. BENENATI: Just is it appropriate to do it before the documentation comes out? Would it not be best to wait and see what the documentation says that Jeff has because there is other pieces of that -- is there not, Jeff?

MR. CRUTCHER: Yes, there are.

DR. MURPHY: This is just a flavor

change, culture change, recommendation that we think we should be in favor of. Really with the results coming out we are going to see how much, who, when and where. But I think going forward I think we are all on the same page, which Dr. VanRoekens is talking about, trying to make a gallant effort. Unless there is some facility, you know, impediment, you know, loss of electricity, loss of power, these kind of things that we try and make a gallant effort not to go on diversion.

DR. PAPISH: Let's table it to the next meeting.

DR. LARSEN: Why?

DR. PAPISH: Because he will have all the data available --

(Everyone is speaking at once.)

DR. VANROEKENS: Again --

DR. LARSEN: There is two questions, one is are we going to use the tracking system? I don't think we need to do anything special. It's like, I would want a central repository for where the stuff is happening and a place

where everyone can check, hospitals, EMS can check what is going on for whatever reason.

The second question is then do you want to abolish diversion as we knew it? That's all.

DR. PAPISH: I think the second question, I mean, really is determined primarily by the extent of the problem, which is what we are waiting on data for. And so if it turns out that, you know, this is, you know, one or two hospitals that have the problem and they have just fixed it then going forward allowing diversion, you know, as needed wouldn't be the end of the world because it's not a problem and mandated it not exist. I think the first aspect there is really no reason we couldn't vote today --

DR. VANROEKENS: Again, I only raise it because I think that some of the hospitals have dealt with boarding issues that are problematic. It's not really the ED physicians, or ED nurses, or EMS. I think it's the hospital's willingness to support the EDs and the operations. If you have a

blanket statement where you say no diversion it forces the issue back to the hospitals and generally can make our lives a little bit better, that would be my only comment on that.

DR. LARSEN: That was the discussion in Westchester and that's what we came up with. And that's the nationwide discussion, that's what happened in Pennsylvania where it's law and a number of other places. There is number of --

DR. VOHRA: Like you said, you have to have the hospital buy in. If you don't have the hospital support and you are sitting at this table and you have a percent of your ED boarding, you are not really able to do a good job for patients and you are forced to divert in that situation. And it sounds like we need to do more and that what we all agree is a problem here --

DR. LARSEN: Well, hospital administrators, their first line always was to come down -- when shit got out of control in the emergency department was they come

down and say, well, let's go for the diversion. Let's go for diversion. And that was the first solution. And, you know, rather than bump it up to the highest levels and say, no, we have a real problem here and get the highest level of the hospital on board right away and say, let's move forward and figure out how we are going to move patients out of here. So --

DR. MURPHY: Andy --

DR. PAPISH: Did it work in Westchester?

DR. LARSEN: Yeah, we have done it. There have been a couple hospitals that have had some problems with it, but basically everyone has complied.

DR. MURPHY: Andy?

MR. LAMARCA: Two issues. One, in the past when we had particular hospital administrators say we are never going into diversion --

(The speaker cannot be heard.)

MR. LAMARCA: -- that means we have ambulances that can't get back out because the patients are on stretchers in a full ER

with no place to go. Hopefully, we are going to make that decision and the administrator is on board. And if you are boarding so many patients and you established but we have saturation and have five to six ambulances outside of the ER, patients on stretchers inside, we can't respond to anybody else in the community.

The second thing is the hospitals now -- years ago used to be diversion for everything or no diverse. Now it's diversion for certain things and not others, which -- again, I think one of the other issues is our communication centers, if they are not feeding that information out to the EMS units coming in, it's a lot of confusion. I know the hospital side you are talking about, but we have very little power to tackle community centers, we need them involved to warn off incoming EMS units.

DR. PAPISH: That would be the benefits of the system. If the hospitals are reporting that their cath lab is down, then the dispatching centers, and as a result, the

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ambulances, would know they are transporting with no cath lab.

MR. LAMARCA: If dispatch buys into it and we don't have central dispatch in all counties so.

DR. PAPISH: There is five so how many --

(Everyone is speaking at once.)

DR. VANROEKENS: Again, with multiple dispatch centers they don't have requirements to report, hospitals don't necessarily have a requirement to report into the Westchester tracking system. If we want to say that's what we should do, that's going to require something from this body stating that, but I don't know that that solves the problem. Again, I hear what Arshad is saying, it's problematic.

DR. MURPHY: Well, I think that one of the things we can say as a body, we would like not to have diversion. We would think that would be a good thing for our community, our patients. And maybe it's not going to happen just because we say it and there is so

many factors involved. I think we always have to be advisory to the area and I think that's a great bit of advice we could give, is let's never have diversion unless there is, you know, those specific circumstances.

DR. PAPISH: And the truth is some information is better than none. If the dispatching centers choose to not look at the website, which is free and easy to click open and look at, that's a problem on their operational end. The fact we are going to make it available and it will be available to them and we will notify them, some information is better than no information.

DR. VANROEKENS: So, again, so I am clear, would the recommendation of this board be no diversion without reporting through the dispatch center -- I mean through the website -- is that what we are looking at?

DR. MURPHY: I think that's a good step forward. And also to say diversion only under catastrophic events. And that we give the flavor of, we prefer not to have any diversion because it just hurts everybody

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when somebody is on diversion, there is no question.

(Everyone is speaking at once.)

DR. MURPHY: It doesn't have to be on -- off the record.

(Discussion held off the record.)

DR. MURPHY: I think what we have to do is reach out to each dispatch because each dispatch has to have a medical director, for each county there has to be a person labeled, it used to be Glen Kay here --

MR. LAMARCA: Turn the page.

DR. MURPHY: No, but I still think he is --

MR. BENENATI: If they do emergency medical dispatch they need to have one, if they don't, then they don't need to.

MS. LEONE-STOLL: If they don't have EMD they don't have to have medical director --

DR. MURPHY: So that might be more of a difficult issue to get weighed in on. In Rockland how many dispatch centers are there?

MR. HUGHES: Seven --

MS. LEONE-STOLL: Six --

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MR. HUGHES: Six or seven.

MS. LEONE-STOLL: Because 44 control is doing Haverstraw now, so it's six, I think.

DR. PAPISH: I think that still doesn't change the fact this would provide a mechanism for them to visualize it because right now they don't have any.

DR. VANROEKENS: Again, we are talking logistics here. The problem of going on diversion, somebody could pickup a phone, call a dispatch and you are on diversion. Who that goes to, is that only county wide, or just to that one PSAP? I think that's the issue that we are struggling with.

DR. PAPISH: Well, I think it solves the problem --

DR. VANROEKENS: If we all agree the only way to go on diversion is to go through this site, maybe that's the way to handle it.

MS. LEONE-STOLL: One of the issues we have is especially if diversion happens at the end of a shift, then they may have -- our dispatch may have put it out over the radio whatever hospital is on diversion, but the

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next shift coming on has no idea. That information doesn't get portrayed. So having a system like this especially if EMS agencies can access, I think is a huge benefit because right now there is nothing. Even if not everybody is on it, or not everybody reports every single time it's still better than what we have now.

DR. MURPHY: You want to make a motion?

DR. PAPISH: So I make a motion that we endorse the utilization of the Westchester -- what is the official name for it?

DR. LARSEN: Hospital diversion site.

DR. PAPISH: -- hospital diversion site for all receiving facilities that would -- are asking to go on diversion going forward.

DR. VANROEKENS: Second.

DR. MURPHY: All those in favor?

So we got it. Just one, Dr. Arshad.

And what about just making a motion about no diversion?

DR. PAPISH: That's a bolder one.

DR. MURPHY: Okay, Craig?

DR. PAPISH: It's not a problem for me

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we are never on diversion.

DR. VANROEKENS: Again, I'm happy to make the motion that we agree in the Hudson Valley not to go on diversion, with the implicit understanding that hospital administrators and the operations of the hospitals and systems have the responsibility to their emergency departments and to the community and both to the emergency department physicians and nurses, because this is not an ED problem.

DR. MURPHY: Yes.

DR. LARSEN: Just a note, when we did this we did send out an official notice from our body saying to all the CEOs and relevant people that this is no longer happening and it's probably something we have to do every so often.

DR. PAPISH: So what are the legs -- say a hospital says, okay, and they just keep going on diversion? I mean, is there any real recourse? You could make them a nonreceiving facility, I guess, theoretically. Not that I'm proposing that,

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but is there teeth to doing that?

MR. NOLAN: Just keep bringing them patients when they are on diversion --

DR. VANROEKENS: Again, we have a duty to the patients too. I know that sounds like one-way to handle it, but that's not the right way to handle it. We want to make sure all patients are taken care of appropriately. And your option of kind of -- we could take away EMS for a while, that might be something they might not like.

DR. PAPISH: Not a small threat.

DR. BUTTERFASS: There have to be exclusions for equipment failure --

MR. LAMARCA: That will penalize EMS to some degree.

DR. VANROEKENS: I would say very clear, we are not looking to penalize the patients, EMS, or ED physicians or nurses, that's not where the problems lies.

DR. BRUCK: Is there a way to report the reason for diversion on the website?

DR. MURPHY: There is, yes.

DR. VANROEKENS: Boarding, eighteen,

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right?

DR. MURPHY: Okay, so he put a motion on the floor. Any seconds?

DR. PAPISH: I second.

DR. MURPHY: All those in favor?

DR. MAO: What was the motion again? I lost it, is he --

DR. VANROEKENS: Again, the motion is, we agree as a body that we will not go on diversion. And we will send out a letter to all hospital administrators and appropriate people, understanding that the hospitals and hospital administration have the obligation to provide access to EDs and for EMS to serve their communities.

MR. BENENATI: And is that with the exception though of equipment or specialty diversion as well?

DR. MURPHY: Yeah, if the cath lab went down --

MR. BENENATI: I don't know if you want to modify the motion --

DR. VANROEKENS: Friendly modification accepted.

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DR. ARSHAD: My comment is, I think we are all in agreement going on no diversion with the exception of technical issues is the right thing for our patient population. I think in order to be more effective with our motion as a collective body we should draft a letter, distribute, allow time for questions and comments, build a consensus and say as a community in the Hudson Valley from an alliance from EMS agencies to the REMAC to the hospitals and executives, we are collectively making this pledge to avoid diversion and empowering our EMS providers to provide the highest quality of care for our patient population.

I think we can table this particular motion until next time, consider sending out a request for comments, questions, and just building consensus. I think it's likely to be more effective. We will get greater buy in at the C level and the executive branch. And I think ultimately we won't have to keep sending out reminders and tapping people on the knuckles with rulers, et cetera, if up

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front we have that buy in community process.

DR. MURPHY: Are you okay with that, Dr. VanRoekens?

DR. VANROEKENS: I think that would be fine.

DR. MURPHY: So I'll draft a letter and send it to you guys electronically. You can look and see if you are good with it, we can --

DR. LARSEN: It should be signed by everyone.

DR. MURPHY: Yeah.

DR. VANROEKENS: Signed by every hospital, agency, director, everybody present here and make sure it's in place for next flu season.

DR. MURPHY: Yeah.

DR. PAPISH: Didn't we send a letter about this a couple weeks ago? So it's not something they already just didn't receive --

MR. VIOLANTE: As a system component --

DR. VANROEKENS: I am so used to that letter.

MR. VIOLANTE: As a system component I

think it would be a great idea in some shape, form, or fashion to include dispatch centers in this process. Because I think that they are not a part of the continuum in realizing that they truly do impact patient care. And some of the things we see is the providers get the patient, get into the ambulance, sent to the hospital and when they call into the hospital two, three, four, five minutes out, that's when they know the hospital is on diversion for whatever reason. And then they have already talked to family, talked to the patient, they have to rework things, family goes to another hospital, you go to a different one. If the dispatch center up front can either put this out to the community on a regular basis, every six hours, whatever. And/or let the agency know when they queue up that they are going to the call, responding, hey, be advised such and such is on diversion for CT. And the crew can have that conversation with the family during patient care, make a decision from there.

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DR. MURPHY: Yeah, that's on the top of my page is dispatch centers. So I'll have to do a little homework --

DR. VANROEKENS: Right, so that first letter or agreement what they would need to know about that, that is the mechanism now for -- even if it's an electrical, the ED is flooded, it needs to be logged into that website --

DR. MURPHY: It's just better communication all around.

DR. VANROEKENS: And the PSAPs need to know that, all the dispatch centers.

DR. MURPHY: Okay, so I'll draft up a letter, I'll send it out to you guys and we'll move forward on that next time. We will get buy in, we'll get it to each one of the medical control facilities and I'll try and reach out to the dispatch centers and we will get a consensus. Okay?

DR. PAPISH: Do the dispatch centers ever have their own meeting for the region or just operate independently all the time and there is no central dispatching? Just

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because it seems like it's a body that has -- essentially they are all doing the same thing in their respective areas, but they don't communicate.

MR. BENENATI: They do have state level meetings and they communicate, you know. But I think some of the breakdown in that communication is simply us in communicating with them. Bill has been working recently with the EMS coordinators, using them as a tool to get to the 9-1-1 centers. I think we are trying to build that relationship, especially with regards to the diversion issue, that's where it became very apparent.

DR. MURPHY: We will also put that letter to the EMS coordinators too of each county, right, that would be another important person to have on there.

Okay, any other comments? Go ahead.

MR. LAMARCA: On a similarly related matter to diversion, I think one of the things we'd like to see, if you could consider it, is actually addressing the Commissioner of Health to start the process

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of allowing EMS to use alternate destination and treatment release. Obviously, tort reforms have been an issue, but alternate destination have had a couple of field tests and we might be able to decompress some of the ERs from some of the stuff they don't require EMS services. You know, right now, you call an ambulance and they have to take you to Article 28 facility. So without any other option many are taking patients that don't need to go there and they are choking. Again, maybe at some point consider if REMAC will send a letter to the Commissioner of Health asking him to consider clearing us for alternate destinations.

DR. MURPHY: Isn't that already in the works?

MR. LAMARCA: There is a policy statement on that.

DR. PAPISH: One of the agencies in Dutchess is trying to get an Article 28 waiver right now --

(The speaker cannot be heard.)

MR. LAMARCA: It's a lengthy process and

more than just what the regulation says. But I think that's the root cause of some of the problems we are dealing with right now is you can't control the flood gates and we are just adding to it.

DR. MURPHY: I thought Lee Burns talked about she has something in the works with the commissioner looking at stuff of this nature. I'll get clarification on it, but I thought that was one of the things they were looking at especially, alternative destinations, kind of tag into that whole community paramedicine issue.

DR. LARSEN: Yeah, I just recently had a conversation with Lee Burns, she seemed quite frustrated with the process. You know, she was not making big head way so I think we need to help push this so that they come in -- she can go, you know, with backing.

DR. MURPHY: I can form a letter from here too, again, from the committee and send it to the commissioner. I think that one of the things I can also see is if we can put it officially on the next SEMAC meeting agenda

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so we discuss it and that way it will be something even more brought forward if all SEMAC looks at it and we can have everyone in the room weigh in on it.

No service upgrade.

Evaluation subcommittee report.

Dr. Arshad?

DR. ARSHAD: All right, so we did have a complaint forwarded to us sort of at the end of the year, which we viewed after our last REMAC meeting. And, Jeff, please feel free to chime in if you have edits to my commentary.

So the complaint was forwarded to our body by Garrison BLS. And they had responded to a cardiac arrest of a 55 year old, which details later emerged the cardiac arrest was unwitnessed. ALS was in obviously dual dispatch and the closest ambulance was Emstar Ambulance that was somewhere on the order of 10 to 20 minutes away and there was some confusion about the time of arrival.

When the paramedic arrived, noted the patient, the BLS -- Garrison BLS had applied

a mechanical CPR device and maxed out their capabilities in regards to the BLS response to the out of hospital cardiac arrest. Once the ALS provider arrived, thought that continuing the resuscitation would essentially be futile, the total time the BLS crew had been on site, in addition to a State Trooper, had been 25 minutes, so say 25 minutes of chest compression. The ALS provider subsequently called the emergency department, spoke to on-line medical control physician, asked for a termination of resuscitation request.

Now, there was some confusion in regarding the details that the physician had received, which that the duration of chest compressions and ACLS level care had been going on for 40 minutes. The medic had, in fact, not tried any intervention, including advanced airway, establishing access and administering epinephrine. The termination of resuscitation request was granted by the emergency physician. The patient was terminated on scene and that's when the

complaint was forwarded to us from Garrison. The crew thought there could have been a greater effort in terms of ALS perspective resuscitation for this particular patient, especially given a relatively young 55 years old.

So we met at the conclusion of the last REMAC meeting and relayed our concerns to the medical director of Emstar, Dr. Brooks. And she subsequently scheduled a meeting with the paramedic and I have an e-mails from Matt Nolan, who is their clinical services director. And I'm just going to highlight some of the points.

So the patient was not a witnessed arrested as no medical provider was present at the time of collapse. CPR and defibrillation were attempted at first responder arrival time and were reported as unsuccessful to the medic after initial ADD shock to presumably asystole. And the call times make it clear that the patient would have been in arrest for at least 25 minutes prior to the paramedic arrival.

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Number two. The paramedic was traveling from being posted central in the county 10 minutes or 18 minutes away due to multiple calls. In fact, the medic was never advised that the call type was for a cardiac arrest.

Dr. Brooks wanted to point out that the BLS crew, upon finding the patient in arrest, should have considered it possible, initiating transport to the hospital and intercepting another unit rather than awaiting the arrival of the medic coming from the opposite direction. There may have been some confusion as to the anticipated arrival time for the paramedic.

On patient contact the paramedic made the decision to seek a field termination and contact medical control. The patient was described as being purple from the nipple line up and being worked for a period of nearly 30 minutes with no ROSC. Medical control agreed with the request, although there was retrospective confusion as to what had been done clinically for the patient when that call was made. The medic claims she in

no way intentionally misled the medical control physician into thinking that advanced life support intervention took place.

The field termination protocol was reviewed with the paramedic at length. And Dr. Brooks did make it clear that there should be more sensitivity to the BLS providers, often times ALS providers come on scene and are callus or can be brusque in their communication. Perhaps, she commented, by being less blunt in considering their perspective the effective communication could have been better. She did not disagree with the paramedics choice to seek a termination of resuscitation. The medical control physician, if unclear as to what resuscitation efforts were conducted, should have asked further questions of the paramedic. The paramedic, I believe, when faced with less than ideal circumstances has the option to seek medical control support, which she did. It was described that in the future she should strive to be absolutely clear with her communications with medical

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control in her description of the circumstances.

So we reviewed that commentary and essentially we thought it was appropriate. There seems to have been some personality issues on scene, which are always unfortunate, especially when dealing with a critically ill patient, especially cardiac arrest. There is clearly some miscommunication in regards to the paramedic and communication with the on-line medical control physician, so I think those points were reiterated and reinforced.

And essentially Mark, Pam, Jeff, Bill and I spoke and we thought this was an adequate response to the complaint that was garnered.

DR. MURPHY: Okay, thank you.

DR. LARSEN: I have one question. So in point number one you had said that the patient had received one shock, that they were in asystole, won't they have had an AD --

DR. ARSHAD: There was a State Trooper

on scene as well as BLS, there was initial shock provided BSA, the rhythm is unknown and the patient remained in asystole throughout the remainder.

DR. MURPHY: Yeah, after that --

DR. LARSEN: Okay.

DR. MURPHY: Thank you. So helicopter committee report and RTAC I'll place on hold because Dr. Berkowitz is not here. The agenda shouldn't say Stuhlmiller, it should be Berkowitz.

Unless anyone has any comments?

DR. LARSEN: The RTAC was just held several days ago on Friday and a number of us were there so I think --

DR. MURPHY: Do you want to --

DR. LARSEN: -- we could give a report.

Yeah. I mean, there was not a -- you know, there was not a whole lot of, you know, extensive meeting. One of the things is for the regional trauma advisory committee picking representatives to the STAC, the State trauma advisory committee, which you know has been as functional as our own state

advisory committee. But anyway, so we actually did pick some folks to do that. They too have to be vetted and so that process is going to move ahead.

One of the big discussions and this has been an ongoing thing for years, is what is the pediatric age? So at least it's been set, it seems that what the American College of Surgeons has set is up to your 15th birthday. So 14 years of age, okay? Now, there was certainly a lot of, you know, discussion about, well, you know, I think Nyack was mentioned their orthopedist won't take care of a patient less than 18 years of age. So what how does that fit in? Well, it means we should follow the ACS guideline of 14 absolutely, but there is going to be local variations, so that was kind of where that was happening.

The other thing, there was discussion about stop the bleed campaign. So most of us probably know there has been this national campaign initiated called stop the bleed coming out of the consensus in Hartford. And

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the idea is to try and make this almost like an ALS skill -- not ALS -- AED skill. So that to train lay people all across the country that with a few simple -- like a two to three hour course you can teach lay people about stopping the bleed. And this will be helpful in accidents, mass shootings, and unfortunately, bomb incidents. And the other thing is that, you know, the placement of some of these stop the bleed supplies in AED sites and in the same sort of fashion that they would be locked and, you know, have to get access to them and can you pullout some tourniquets and quick clot and that kind of stuff.

So anyway one of the things that is happening is that there is -- that Westchester Medical Center will be taking the lead on this, that there is a course available so that, you know we, can all become instructors very easily by taking this. And it's going to be made available at the next RTAC meeting, which I believe has been scheduled for -- it was in May -- sorry,

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I'll come up with that in a moment. But anyway, so there will be an instructor course that anyone is -- can come to. You are also going to get a little kit and there is also the ability to buy those kits for quite cheap that are to be dispersed to folks that you are instructing in the stop the bleed campaign.

It seems like a good course. It seems like a good concept that's going to be spread out to the public, just like CPR, just like AEDs. And I think we should take a lead in that.

One of the things that was also stressed is that we need to -- that had been observed somewhat anecdotally by the trauma centers, that they were seeing trauma patients come in from EMS that did not have oxygen on. This was felt that certainly if there is any hint or possibility of any kind of traumatic brain injury that oxygen is key. And even though there may not be obvious indication right there, that we should certainly err on the side of putting patients on oxygen. And we

need to restress that with our EMS crews, so that was a big item.

There is also, you know, a kind of a list of who is now trauma centers, okay? And people are coming up with approval. They are actually going to issue a new list, that list has not come out as of yet. So there will be a new list coming out so everyone will know that there are additional trauma centers. And people may or may not know Vassar Brothers now has a trauma designation --

DR. MURPHY: They are level two, right?

DR. LARSEN: Yep. And let me -- so Nyack is level three, Orange Regional is level three, there has been some --

DR. VOHRA: Level two.

DR. LARSEN: Three?

DR. VOHRA: Two.

DR. LARSEN: Sorry. All right, anyway I think that was it.

DR. MURPHY: Okay, thank you.

MR. HUGHES: Next meeting is May 12th.

DR. LARSEN: Okay, so that's going to be at Westchester Medical Center. And there

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also will be additional notice sent for people that want to take the stop the bleed course. So it will either be before or after the RTAC.

DR. MURPHY: Excellent. Thanks.

Quality improvement report, Jeff?

MR. CRUTCHER: We did originally have Image Trend scheduled to come in in January and we had to postpone that due to illness. They have rescheduled for March 20th and March 21st. March 20th they will be here from 6:00 p.m. to 8:00 p.m., the next morning they will be at MidHudson Regional from 10:00 p.m. to noon.

This is not a two-hour sales pitch, it is a two-hour educational session explaining what data can be gleaned by the agency from the State bridge. So we are not looking to get just agencies and agency representatives that are not electronic, we want folks that already have EPCRs and maybe having some issues, maybe having some quality data questions. Basically anything they want to come in with and get out of the session, we

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will be there to answer whatever questions they have. That's it.

MR. VIOLANTE: What was the time for the 20th?

MR. CRUTCHER: 6:00 p.m. to 8:00 p.m.

DR. PAPISH: Did anything come of the Coverdell grant?

MR. CRUTCHER: Bill can explain that.

MR. HUGHES: I was just going to mention that because part of it will require REMAC support.

New York State has given us an opportunity to apply for a grant. There is two regions that will get grants within the State and the grant will give a regional bridge that will allow reporting into the regional bridge and information dispersed back to the hospitals and to the region. And it will setup a bridge for hospitals to get PCRs immediately as they are being processed. It also allows for money to go to EMS agencies to help them convert to electronic PCRs. There is a lot of conditions on getting it and even regions applying for the

two grants, but we are fairly prime candidate for it because we have two Coverdell hospitals, which are stroke centers, in our region. Actually three if we count Westchester as being our primary trauma center as a hospital within our boundaries or within our region.

And then we need to have a substantial amount of paper PCRs, which we still do. We have almost 70,000 paper PCRs this year, which is a fairly high amount. We are at about 50 percent on EPCRs so that would also be in our favor. They also want to make sure that the REMSCO and executive director of REMSCO would be willing to participate in this and do the work that is involved in it. I spoke with Rich Parrish -- I spoke with Bob Cuomo because Rich Parrish is on vacation, Bob is our Vice-President. And he was very excited and would really want to get involved so that the REMSCO would be involved. And then they want to make sure that the REMAC and hospitals would be participating in this.

So it looks like we makeup a good

composition. Jeff and I will work on writing up what we have to do, have it submitted by the 15th and implemented by June 1st, I believe. So it has to move quickly when it does happen, but it could bring substantial money into our area for the agencies. I think they will give up to $3,000.00 per agency. Now, it could go to different amounts to different agencies, but no more than 3,00 to an agency. It could be a commercial agency, it could be a volunteer agency, could be a municipal agency, it doesn't make any difference, to purchase either hardware for EPCRs or to pay for software for conversion or interface to a regional bridge. So looks like a good plan, we are going to try our best to get that grant.

DR. MURPHY: So you have to write a grant proposal and put it through --

MR. HUGHES: They actually really don't want a full grant proposal, they want it minimal --

DR. MURPHY: So your statistics, why you

qualify, what would be the pros and cons?

MR. HUGHES: Right. And how much support do you have within your region.

DR. MURPHY: And that REMSCO buys into it.

MR. HUGHES: Yes.

DR. MURPHY: That's fantastic.

DR. PAPISH: This was one of the biggest barrier of any -- of the agencies that ever said was, we don't have the $500.00, or -- you know, to do this annually. This fixes that problem. If that really is the problem we should be able to get everybody compliant to get this money. Of course, the other tie in is how the hospitals are going to respond, because I think -- does it require a T way information, or is it just a feed into the hospital?

MR. CRUTCHER: For the Coverdell hospitals it's a web-based application so there is not any issue going through the hospital fire wall.

DR. PAPISH: That's great -- not great for what we really want, but it's good.

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MR. HUGHES: It's a real big step.

DR. ARSHAD: What is the term for the grant? Is there any threat once an agency goes digital, once the grant expires they may not have the funding or resources to continue the electronic --

MR. HUGHES: It's a three year grant, but it's a one time amount of money of $3,000.00 to the agency. And once you do go electronic, you can't go back from it. So -- but the cost of doing business at that point is only per PCR, so if it's a small agency it would be probably in the area of $2.00 a PCR, that's your annual cost, the number of the PCRs created times that, that is the only ongoing cost.

DR. PAPISH: That's ALS, BLS is cheaper --

MR. CRUTCHER: Yeah.

DR. PAPISH: -- talking about $350.00 a year. If they are that cash strapped then they are going out of business.

MR. VIOLANTE: Can an agency use any PCR vendor or a specific one --

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MR. CRUTCHER: Any PCR vendor approved by New York State as being Nemesis 3 compliant.

MR. VIOLANTE: Can agencies get data back from the hospitals then from what Mark is talking about?

MR. HUGHES: Yes.

MR. VIOLANTE: That's a big QA issue we were always talking about.

DR. PAPISH: The real question is will they?

MR. HUGHES: At least the Coverdell hospitals should be participating in this because they are the ones sponsoring this. So we would assume you would get that information from those hospitals at this point.

DR. MURPHY: Okay, thank you.

Protocol committee, Mike?

MR. BENENATI: Nothing further.

DR. MURPHY: Yeah, we pretty much covered it under the protocols.

And everybody is clear with the dates and all, so April 15th, go live. Have your

educational between now and then.

MR. BENENATI: Yeah, so for the agencies that are in the room the region will send a complete packet for all the information so you have all the tools you need to roll it out.

DR. ARSHAD: If anybody has any friends that have Android devices, if you could kindly test the app to see if it's functional.

MR. BENENATI: Well, we said it's not. It still says coming soon --

MR. LAMARCA: On the update.

DR. MURPHY: New business? Any new business to bring up?

DR. VANROEKENS: One item. This relates to 9-1-1 centers. I don't know if you saw the article in the Wall Street over the weekend. 9-1-1 centers through iPhones basically were hacked in October in Washington and Arizona as well, and it generated -- the centers were shutdown. So the question, you know, is which of our 9-1-1 centers or PSAPs actually have the technology

to prevent the hack or jamming of the frequency, just to put if out there when you send a letter --

DR. MURPHY: I didn't see that article, so it was D.C. --

DR. VANROEKENS: Basically the phone was hacked and now the iPhones are made safer and they wouldn't allow that. Every iPhone that followed that that downloaded a link dialed 9-1-1 shutting down the 9-1-1 center. True, it was only a brief period of time, but this can happen unless you have protections on the phone. But the 9-1-1 centers, most of the centers and PSAPs don't have the cyber security to prevent some of those things.

I only raise it just to --

DR. ARSHAD: So I'll piggyback on that comment. I attended an EMS cyber security lecture this past week in Salt Lake City, but a staggering statistic they shared was, the FBI estimates a third of all digital health care files have been hacked in some way, shape, or form. A large majority of that has to do with the Aetna Health Care hack, but

EMS agencies are certainly vulnerable to this. So we need to take best practices and precaution. And I took notes if anybody cares to talk about this in terms of software, people are deploying at the agency level to help protect themselves. And then as individuals we are, of course, highly vulnerable as well, so we have to take best practices and precautions.

So basic things to do, strongly consider a password manager, which is -- a password manager is a bank that is securely storing your passwords and you click onto it when you are logging onto Facebook, for example, you log in via the password manager and it automatically logs you in. Because we will have a host of the passwords to remember in our brains and alter a letter, or digit, or capital so those are highly vulnerable as personal and individual.

DR. VANROEKENS: I just ask my kids and they say don't click on any link --

DR. ARSHAD: The problem is --

DR. VANROEKENS: -- times you need it.

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DR. ARSHAD: -- EMS agency, they were sharing e-mails that were -- appear to be sent by the CEO of the hospital -- CEO of the EMS agency to their, whatever, somebody was holding the purse string, saying, hey, we need to close this account now. The e-mails were appropriate, the billing, reason for the billing. So the e-mails being crafted are so clever that at some point links are going to be clicked and you need to have not only the appropriate antivirus protection, but another thing people don't understand, including myself as well, is the appropriate malware. So there are two different suites of satisfactory wares, the malware essentially protection your computer from the Trojan horses once you click on that link, something gets downloaded and now an executive file is --

(The speaker cannot be heard.)

DR. MURPHY: A little synopsis to the group --

DR. ARSHAD: Sure. I think I might be able to download the slides to the --

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DR. VANROEKENS: Oh, no, don't send me a link.

DR. ARSHAD: I'm going to send you a link -- I'll try and attach the Power Point slides.

DR. MURPHY: Say the word yes.

MR. BENENATI: How appropriate --

DR. MURPHY: No, I would like it.

MR. BENENATI: It would be great.

DR. ARSHAD: I think we have to start paying attention to that.

DR. VANROEKENS: It's easy to avoid the letters from my -- but these other ones are a little tougher.

DR. ARSHAD: Another quick comment, so those folks who have NAEMT agencies or educators in their midst just had the privilege of developing over the past two years a course called all hazards disaster response, formulated from my experience in the Hudson Valley. So I think our community is representative of a lot of communities, not dense urban, and certain parts are not super rural, but the every day MCI, as Dr.

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Mao likes to lecture about, harnessing additional resources in regards to mass casualty disasters, we aim some of the State and Federal assets that are available --

(The speaker cannot be heard.)

DR. ARSHAD: -- it was a request by ASAP, the EMS committee developed a hospital disaster response program, but there was no EMS training specifically dedicated to the medical response of an MCI or a disaster. And we know that the ICS system, incident command system, is designed for a broad host of providers, from NGO, to law enforcement, to first responders, to EMS, to everyone that has an alphabetic acronym. But there was no course designed specifically for the medical aspects of disaster response so that's what we aimed to do. If you guys have educators that are NAEMT educators, the new course will fall in the --

(The speaker cannot be understood.)

DR. ARSHAD: -- et cetera, et cetera, so for folks or instructors in those disciplines it's a simple two hour module they can take

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and become AHDR instructors and we are hoping to host a couple local classes too.

DR. MURPHY: So you call it all hazard --

DR. ARSHAD: Disaster response.

DR. MURPHY: Thank you.

SEMAC. So we had a meeting on May 10th, just to kind of bring a synopsis, our protocols were approved. There was a great deal of discussion regarding New York City protocols. The protocols move forward with some changes and a motion for a BLS protocol revision was tabled because there was just so much controversy about what we are allowing BLS to do and changing of the curriculum and the way the change is going to occur, so that was tabled.

Check and inject, the program, the demonstration project that Dr. Dailey had done with epi, was approved. The Commissioner of Health signed off on it so now it can go forward and anyone can participate.

MR. HUGHES: One thing, we are still

waiting for particulars from the State how we participate. Would we need some kind of collaborative agreement, or if we need some paperwork from each agency that is going to participate, but it should be moving quickly.

DR. LARSEN: There is also some question about the availability of the special syringes and their manufacturer.

MR. HUGHES: Right.

DR. LARSEN: Or manufacturers.

DR. MURPHY: Yeah. That was probably the biggest hurdle for them in that whole project was to get those syringes manufactured at a reasonable cost. And then Lee announced that two more hospitals had entered into the blood program and that was about it.

If anybody else was there, if you think of anything I missed, that was about the nuts and bolts of the SEMAC.

No PAD, Epipen, Albuterol glucometer or Narcan to approve.

Open forum. Anything anybody else wants to bring forward?

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Any questions, discussion, concerns?

All right, I'll ask for a motion for adjournment?

DR. VOHRA: Motion.

DR. MURPHY: Second?

DR. BUTTERFASS: Second.

DR. MURPHY: Thanks everybody 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