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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, June 4, 2018, at 9:35 a.m.

Yvette Arnold,

Court Reporter

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Director

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DR. JAMES CHUNG,
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NORTHERN DUTCHESS HOSPITAL

DR. WILSON, (Via Telephone)
Director

NYACK HOSPITAL

DR. RABRICH,
Director

PUTNAM HOSPITAL CENTER

DR. BUTTERFASS,
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DR. MARK PAPISH,
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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 :

RICHARD PARRISH
ANDY LaMARCA
MICHAEL BENENATI
BJ LEIDNER
JAMES JENSEN
MICHAEL MURPHY
DAVE VIOLANTE
ISRAEL KNOBLOCH

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DR. PAPISH: We have roll call.

Bon Secours?

DR. VANROEKENS: Here.

DR. PAPISH: Catskill? Absent.

Good Sam?

DR. MAO: Here.

DR. PAPISH: Hudson Valley?

DR. CHUNG: Here.

DR. PAPISH: Health Alliance?

Northern Dutchess? Dr. Wilson?

DR. WILSON: Yes.

DR. PAPISH: Here -- awesome.

Nyack?

DR. RABRICH: Here.

DR. PAPISH: ORMC?

Putnam?

DR. BUTTERFASS: Here.

DR. PAPISH: St. Anthony's?

DR. VANROEKENS: Here.

DR. PAPISH: St. Luke's?

Sharon Hospital?

Vassar?

DR. ARSHAD: Here.

DR. PAPISH: Westchester and Westchester

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REMAC?

DR. LARSEN: I am present.

DR. PAPISH: Have you had a chance to review the minutes? They were sent on-line.

Old business? The BLS protocols, there was a session and changes made at the SEMAC a few weeks ago.

DR. RABRICH: The BLS collaborative group has been meeting. The substantive -- the EMC made their recommendations, those have been incorporated by working with the group. They were presented at SEMAC as a first introductory reading with a plan to vote in the fall so people can review them over the summer, open comment period. Now you can submit your comment to any member of the collaborative working group for your region for a reading and voting at the September REMAC -- SEMAC SEMSCO meetings.

DR. PAPISH: There aren't any substantive -- it's more procedural.

DR. RABRICH: A lot is procedural cleanup, cleaning up the definition of pediatric patient, that kind of stuff. There

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is not many significant medical changes, most notably is stroke. There is a note there about following your local protocol regarding you know diverting to a comprehensive stroke center and recognizing a lot of regions are now looking at this --

DR. PAPISH: Are they leaving that up to the regions?

DR. RABRICH: At the moment.

DR. PAPISH: Is that the game plan?

DR. RABRICH: Yeah.

DR. PAPISH: Which is something that we will, I guess, talk about later.

AEMT level of care. Mike, do you want to --

MR. BENENATI: Certainly. The protocol committee looked at this over the last several months and I believe you all should have received an e-mail late last week from Karen. And I'll just take a minute to summarize what that is in the event you did not get a chance to look at that.

So as we move forward the protocol committee does recommend the adoption of

advanced emergency medical technician level in the Hudson Valley, both as a stand alone program, but also a supplement for those agencies that are already operating at the paramedic level. The providers would be required to sit for protocol exam similar to that for paramedic, which would include five modules and one hundred questions. ACLS would not be required to operate at this level. However, certainly it is always encouraged. PALS would not be required to operate at this level, but also is certainly encouraged. We developed a list of minimum equipment which must be carried by the agency in its ambulances and AESVs. There is a slight modification I'll talk to you about later on in the presentation with regards to that based on a comment that we received. There would be requirement for two tiered dispatch of paramedic units for calls that meet the EMD criteria. Advanced EMTs can operate -- can cancel a paramedic unit once a comprehensive documented assessment has been completed and the higher level of care was

determined not to be needed. All cancellations, of course, must be appropriately documented. All AEMT level agencies would be required to have the following approved BLS adjuncts; AED, glucometry, Albuterol, Narcan, Epinephrine, pen and/or injectable, CPAP, and may be required to have the ability to acquire and transmit twelve lead EKG as the REMAC deems necessary based on location and available destinations, so that would be an additional option. All AEMT level agencies will be required to carry pulse oximetry, need to have a QI program in place, agency needs to have REMSCO credentialed medical control physician as their medical director. And for agencies desiring to upgrade to advanced emergency medical technician must complete an ALS upgrade application and must provide the level of care 24/7.

The comment that we did receive earlier on since the document was released was, there was in the equipment list a note for pleural decompression needles, that was discussed

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last week or two weeks ago at this point in Albany. But there is some discussion that that should be a regional and agency option and that the agency is required to do the training for that since its not in the scope of practice and -- so that the agency must do the training.

And then there was a discussion with regards to changing the list of equipment to from of a minimum required equipment to that of recommended minimum equipment and possibly also adjusting some of the numbers, for instance, in some of the cases there are two laryngoscope blades rather than just one.

At this point I'll turn it over to the Chair for discussion, but -- you know, we've talked extensively about this stuff and feel, you know, with the changing in the landscape this maybe a beneficial program, you know, with critical cares now being eliminated at the State this may fill a nice void in the region and certainly like to see it move forward.

DR. PAPISH: We had voted on allowing it

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to move forward previously so now do we just have to vote on the program as written?

MR. BENENATI: I would say that would be appropriate.

DR. RABRICH: Just a comment on the needle decompression, at the SEMAC meeting it was if appropriately trained, equipped and authorized by the region. The intent of it was to allow practical environment, EMT, AEMT to do decompression in specific circumstances where it fit the need of the agency and the region approved. While it shouldn't be on the minimum equipment list, we shouldn't totally eliminate it.

DR. PAPISH: I mean, the only indication, as I thought it was discussed was for traumatic cardiac arrest.

MR. BENENATI: True.

DR. RABRICH: Exactly.

DR. PAPISH: By all means, I don't think you are going to hurt anybody.

Does anybody have any questions about it anybody -- everybody feel sufficiently informed to make a vote? All right.

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MR. BENENATI: So just change the word required to recommended with the equipment list and the provision then for the change for the pleural decompression.

DR. RABRICH: And then we leave the numbers on the list up to you guys and --

MR. BENENATI: We will reevaluate it --

(Everyone is speaking at once.)

DR. RABRICH: I don't think we need to vote on a specific number --

MR. BENENATI: I think that is what is expected --

MR. MURPHY: I think if we use the term recommended and allow the agency to determine based on utilization, demographics, logistics, et cetera, and what, you know, their equipment deployment is so they can satisfactorily take care of their patient population, I think that would suffice, rather than saying two of these, three of these. Then we are going to put a trailer behind some of the EASVs, so leave it as recommended and agency specific --

DR. PAPISH: Yeah. I think that is what

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we are all leaning towards.

Okay, do we have a motion?

DR. RABRICH: I move that we approve as presented.

DR. PAPISH: All right -- we need a second.

DR. VANROEKENS: Second.

DR. PAPISH: And a vote?

DR. RABRICH: Is this a roll call vote?

DR. PAPISH: I think it is a roll call.

DR. WILSON: Aye.

DR. PAPISH: Dr. Wilson, aye. All aye?

(Show of hands.)

DR. PAPISH: One, two three, four, five -- it's unanimous. All right, it's approved.

Moving along. Mission Lifeline STEMI protocol control. I think Dr. Yen from Vassar wanted to discuss Mission Lifeline.

DR. YEN: Thank you for inviting me, David Yen. Y-E-N.

How many of you all know about Mission Lifeline? A show of hands? Because some of this will be review and some might not be.

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I actually knew nothing about it a year and a half ago but the Heart Association is actually trying to really improve -- I don't know if this works, David.

MR. VIOLANTE: Can you come closer?

DR. YEN: So basically we started this program about a year and a half ago with basically a general meeting among the hospitals and then started implementation about the second quarter of last year. And it's just kind of a review about what we are trying to aim now towards STEMI and what we are aiming for in improvement. Because I think we reached a point where once a patient gets to revascularization center what improvements we can do once we get there. So I think we are focusing more on getting the patient quicker to revascularization center.

So this is the Mission Lifeline overview, looking at goals of where delays occur, getting EMS to get to patients quicker, patient recognizing the symptoms quicker and trying to look at delays between telegraphing the EKG to the respective ER,

and subsequent activation of the lab, and then subsequently trying to figure out a good triage plan if you are at a center where you can't get a patient to a revascularization center within 120 minutes, then you can give lytics within 30 minutes is the goal. So those are the goals as we sit there. Our goal is to get from EMS first contact to balloon in 90 minutes, which is lofty. A lot of times we have been happy in the revascularization sense to getting balloon within 90 minutes of getting patient to ER. But if we backtrack to first medical contact it's difficult to get the time frame unless you are in more of a city dwelling where the transfer times aren't that prolonged.

Self-transport is someone basically comes into the ER we're trying to get it within 90 minutes. And if you are at a center that doesn't have revascularization we want to transfer and get it open within 120 minutes if possible. So that's the whole kind of concept of Mission Lifeline overview. This is kind of what we engaged in the -- we

would like to try and get prehospital activation of cath labs from the field and looking to bypass the emergency room as appropriate. And also from transfer hospitals try and meet with them and improve streamline communication between the hospitals. I think the big problem is to reduce the time in ED, time in and out for patients that are transferred to centers that don't have revascularization, the time frame of that can sometimes be prolonged if you look at the data and we want to try and improve that if possible. Also, with walk-in patients, which is difficult sometimes with the urgent cares and sometimes primary care doctor's office walk-in patients can be difficult as well and we try to recognize those atypical presentations and try and get EKG within 10 minutes in the centers. So we will focus more on engaging EMS and transfer time in and out.

So this is kind of the Mission Lifeline when it started. It started 2007 and basically it was started because they

recognize that there was a -- really the mortality reduction was really plateauing and trying to find out if there was anyway to improve care with these systems. They wanted to kind of get with the guidelines to track both hospital, regional and improvement protocols and basically focus on acute MI patients.

So this was the project plan and we are kind of in phase two to three right now. But initially what they did was met with the revascularization centers in the Hudson Valley. And they established a steering committee, which I'm a member of, and then basically looked at the baseline data just to kind of see if there were enough patient population cases, et cetera, for them to enroll the hospital and/or referring center into the project. We had our project kick off meeting, I believe about a year ago at West Point and then we started our conference calls and reviewed the data monthly after that. And we are now trying to develop regional protocols we are kind of in the

phase two to three range now, meeting with hospitals, meeting with ERs, trying to establish a protocol in which people can follow, hopefully it will make it easier to get these patients quicker to the revascularization center.

Phase three is looking at the data, trying to implement feedback and target for non PCI centers in EMS. We have had some difficulty with the non PCI centers and I think we sent a survey out to EMS before in the past to try and get some idea what their problems have been with, logistics of getting EKGs transmitted, cold spots where there is no good cellular service, et cetera. So these really are goals. As I expressed before our goal is 75 percent of cases within 90 minutes to patient's who -- from first medical contact to primary PCI, or door to needle time less than 30 minutes for those that receive lysis. For transfers if you get to a different hospital that doesn't have revascularization our goal is 120 minutes first medical contact to transfers. Walk-in

patients, EKG within 10 minutes. And number 4, which I don't think we do well is feedback to EMS and referral centers. I think a lot of you all do a lot of hard work and don't get feedback from us. When we do get cases of how well we did and what we can improve usually it's only in cases where there are delays. So I think number 4 is important and we don't do a good enough job with that.

This is an example of kind of the data that can be given. If you look, these are in purple, is the first medical contact to EKG so tracking times in which the EMS arrives, how good, and in blue, EKG to notification call to the ER, and subsequently red is call to activation. So we can kind of track these time frames and see how we are doing and look at ways in which we can improve things.

This is kind of the baseline data we get for patients who actually get to the facility to device time, this is transfer times. So we look at blue, it's basically patients who arrived at the door to the first facility, the orange is kind of door in and out, and

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green is once they get to the revascularization center to the time to balloon. So we can look at that data as well and those are national benchmarks and the goals in red respectively.

So in our region we have probably five or six revascularization centers. The ones in black are referral centers, obviously a lot more down in New York City. So this is kind of the area we are encompassing here. And I believe we have five revascularization centers now in the Hudson Valley that are part of Mission Lifeline.

And does this work or why are we doing this? So they did various studies prior, this is in Hartford, and they basically showed a reduction of about 13 minutes in patients taken directly to the PCI center. And you can see the majority of the reduction time was the ED time actually from 31 minutes to 18 minutes. It's kind of hard to improve the cath lab time. And the first medical contact to ED door time was about the same. And on the other panel they improved about 30

minutes or so roughly of transfer patients taken to non PCI center. And the biggest improvement was in the door in, door out time. And that's typically what we want to target to here in non revascularization centers is the door in door out time.

If you look at nationally this was presented last year at the AHA, it was published in circulation and they basically took Mission Lifeline and implemented it in about 10 regional centers. And basically they are trying to determine if this has actually improved outcomes or not. So a big trial in 12 metropolitan regions, about 21,000 STEMI patients, 10,000 from EMS to PCI, so just looking at PCI patients, not the ones that got lytics. It was lead by the Duke Clinical Institute, and 139 PSAT hospitals, 970 or so EMS agencies, 12 big metropolitan regions, Albany was one of them, New York City, Houston, Hartford, Denver -- you can read them here -- so it's kind of a conglomeration of a lot of different regions. And really if you look at the regions there

was actually quite a spread of acute MI outcomes, you know, you have the Northeast, which does pretty well, and the South sometimes not as well, midwest, West Coast, they do pretty well, and Southwest.

So what they found was basically once they took the baseline data and implemented the Mission Lifeline protocol and basically determined that there was a significant reduction in the first medical contact to lab activation. By about -- roughly what -- 12, 14 -- 14 percent, 15 percent or so in the green there -- pretty much across the board, which was a good thing. If they looked at emergent department dwell time for transfers they showed a significant reduction across the board with most of the patients getting out of there in about 20 minutes or so. The majority -- still about 33 percent, greater than 30 minutes, but certainly better than 42 percent. If you look at mortality of patients who received first medical contact to cath lab less than 20 minutes, they did better than those greater than 20 minutes,

kind of makes sense, about 6,000 patients or so. And if you look at outcomes there wasn't any major difference between bleeding, stroke, or cardiogenic shock patients. In hospital death though was reduced from 4.4 percent to 2.3 percent and heart failure was decreased from 7.4 percent to 5 percent and those were very significant.

So if you look at the patients who were -- or the centers who are in accelerator two, if you track their mortality across the board from 2015 to 2017 you showed a steady decrease in in hospital mortality for STEMI that got revascularized. And if you looked at the data for patients who were not -- or patients who were in regions that did not have -- or participate in Mission Lifeline you showed that their mortality pretty much stayed the same or maybe up ticked a little bit. So I think this is pretty good data Mission Lifeline does work, it does lead to clinical outcome data that are important and if we would implement it would be a good thing for our region. So that's basically

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what they concluded.

So I'll give you some of our data here. This is our goals just to remind us, greater than 75 percent of cases within 90 minutes first medical contact to -- our goal is greater than 75 percent of cases to open the artery from first medical contact to getting the artery open. And these are our region aggregates, these are our hospitals on below A, B, C, D and E, those are the five hospitals that have primary PCI. And the numbers for some of the hospitals are small so we take it with a grain of salt. But in general in the aggregate we showed improvement from about 75 percent, kind of a dip to 70 percent in the second quarter to about 80 percent in the most recent quarter, getting the artery open within 90 minutes of first medical contact.

Some of the hospitals do better than others. I know hospital A is very forthcoming, they are in a more city environment so they recognize their transfers times are not as long as for some other

hospitals that are more rural.

This is EKG within 10 minutes of arrival. This is not just urgent care, but across the board -- you'd think this would be 100 percent across the board but in reality it isn't, it's about 80 percent I believe in the last quarter we looked at. The goal is greater than 75 percent.

These are transfer times from first facility to those that have revascularization capability. There is only three hospitals out of the five that receive primary PCI that get transfers currently -- two -- sorry. You can see it's difficult to get the patients quicker from these facilities, only about 50 percent for the last quarter and 75 percent got the artery open within two hours after arriving at the first center.

So the last, I'm just going to look at -- you can get the slides from David or me if you like -- the protocols, I think that Alana, that works with Mission Lifeline, met with some of the referring centers and I think the goal is to meet with everyone if

possible and try and get kind of a protocol setup where things are relatively straightforward and there hopefully wouldn't be much decision making to be made. We follow algorithms and these are algorithms we have seen before, but to put it in one or two pages of paper I think would be important. Because we certainly get a lot of calls and sometimes confusion about what to do, what to give, et cetera. And I think if we streamline that I think that would be improved.

And these are just basically medications that we like to use, you know, and dosages, et cetera, just a really quick sheet you can initial off when you give it. It's from the receiving end something that is difficult for us to determine what the patient actually got at the emergency room, or what time frame it was if you have to flip through a gazillion sheets of paper. So if we had one sheet with everything on it, that would be great and this is one of the reasons we have this. Plus it makes it easier for the data

collectors to know exactly what happened and when the patient arrived, et cetera.

This is a great transfer form here. I think it's important that if we can fill this out that would be very good. It just gives as you quick snapshot of when the patient contacted by EMS, when they arrived at your facility door, in out time, et cetera. Hopefully, it's not going to be too laborious to complete, but we certainly can tailor it to your facility if needed.

And then just upcoming, there is -- also a part of Mission Lifeline is also to raise community awareness. So hopefully we will have some just posters or whatnot, billboards, et cetera, just trying to get people to call 9-1-1 quicker, rather than drive themselves to the ER centers. I'm sure most of you have cases in which patients decide to drive themselves and not call 9-1-1 and delayed their care.

And this is the feedback form. This is an example of one of the forms that we can give your facility and/or EMS. I don't think

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we have done this as well as we could in the past. Certainly for all cases we would want to do and try to understand from your standpoint what are the delays and what are the issues that sometimes arise that we can improve upon.

And I think we met with Catskill, Northern Dutchess and Mid Hudson recently, and the other five hospitals there I think they're planning to meet with in the future just regarding the protocols and any questions, et cetera. And I think that's going to be within the next few weeks, I believe.

And this is just some contact names Alana Davis, who couldn't be here today. She is the director of Mission Lifeline in New York. That's her contact information. She is happy to answer questions, either with phone calls or personal with your hospitals to implement the protocols if you are interested. And that's just my information there.

That's it.

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DR. PAPISH: Thanks. So going forward I guess they're going to be contacting all the hospitals to gather -- the non PCI performing hospitals to get information -- get information gathering. What about the individual EMS agencies, or are they using EMS reports from the hospitals as the information source?

DR. YEN: We met with some -- actually we have increased our executive meeting to include EMS also. So we are trying to work with EMS providers directly to improve and hear from them where delays can occur, which I think is important because a lot of times we have no idea what they are doing out there and difficulties they have trying to transmit and get things going.

DR. RABRICH: And there is opportunity for EMS agencies to receive recognition from Mission Lifeline. So if they are doing their first medical contact to EKG within 10 minutes and meeting all their metrics for Mission Lifeline they get bronze, silver or gold awards from Mission Lifeline as an

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agency.

MR. JENSEN: It's a very active program in the REMO region. Dr. Dailey has done a fantastic job with the program in recognizing EMS and his programs that he puts out are being tailored to our abilities at Vassar and to raise awareness with EMS and make sure that they understand the seriousness of these type of calls and possible diverting past or local facility coming to PCI.

DR. PAPISH: Sure. Makes sense.

DR. LARSEN: I'm on the steering committee too and I think the real challenge is in -- and this is, you know, what we found is figuring out how to get this data back to EMS. Because a couple things -- I mean, one of the things, you won't as a hospital get your little gold star if you don't get your data back because that's the fourth important component here. So we need to figure out -- and, I mean, it's probably unfortunately going to be different from agency to agency and because we have so many agencies with different sort of means of communication is

getting that thing -- getting that info back to them. So you can see that chart has -- there is a lot of time, but I know for the EMT personnel who is bringing the patient in, what they want to hear is the narrative. They want to hear, you know -- yeah, the times are great, but what happened to the patient? What happened to the patient in the ER? What happened to the patient up in the cath lab? How did they turn out? Did they get discharged from the hospital in four days? You are not going to be able to know that if you are giving feedback back in 48 hours, but you are going to know something and that's what the day-to-day EMS folks want to know and that's what is going to inspire them to try and jump on board with this thing. Okay, we made a real difference in people's lives here and we got some feedback, we actually found out what happened to that patient. That's why we will do everything we can to compress times and rapid transfer times from hospital, that to me is the biggest challenge is trying to figure that

out.

MR. JENSEN: Dr. Larsen, thank you for your input. We have -- at Vassar and Health Quest we are working on a program to bring that ability to every call, not just STEMI, not just stroke, through a vendor program that we are able to send feedback out to EMS provider as soon as the clinical information has been posted by the ED, or the cath lab, or neuro. And that project is well in hand to be launched in 2019 as long as some of the hurdles are taken care of. I can see 100 percent compliance with all STEMI, neuro and trauma, as well as pediatrics and hopefully about 95 percent on all calls.

DR. PAPISH: That is the goal. The trend is to give more information and feedback back to the unit so they can learn and improve.

MR. BENENATI: This is an outstanding program really and I think this really raises the bar, first of all with STEMIs, but stroke is right behind and, you know, knocking right on its door. We really have done this with

trauma for the last 10 or 15 years and I think this is a natural segue into that. I think what is important in the message I think that Dr. Yen delivered today is that hospitals and EMS need to be aware the program is out there and there are benchmarks we should all try and reach. There are several hurdles, especially in EMS, but we need to spread the word and encourage our participating agencies to buy into this program because it does make a difference.

DR. PAPISH: One of the things, you know, sort of related more to the interfacility transports -- which I know we don't really govern the realm of commercial transports -- is just the non PCA hospitals just recognizing they need to call the ambulance as soon as they see the EKG, rather than waiting to speak to the transfer center. I think it's the biggest decrease in time you get.

DR. VANROEKENS: Just two comments. One, the sharing of information always makes a difference and typically that doesn't occur

even within systems. We do get some back from neuro intervention, we don't get it for trauma and some of the cardiac cases as well too. I'm talking about sending facilities and I'm also talking about EMS. So often times EMS is what happened to that patient, well, we can't -- so to the extent we can get any of that information just very basic it is being done some, but not as much as it needs to.

The second point, which is actually more operational is that we will not get ambulances -- we can pickup the EKG in some of these outlying hospitals, diagnosis the STEMI, we can diagnosis even before they get to the ED and if they are brought to non PCI facility that creates a real problem and we are looking at transport times one, two, three hours, and they can be flight, there cannot be flight, often times we are giving lytics when the optimal treatment is PCI for these patients, at least for cardiac. I want to make sure on the record that's an issue. We don't influence interfacility, there is no

jurisdiction, but to allow that to happen I think we need to be aware of that and that occurs for trauma as well.

DR. PAPISH: One of the things that probably could improve that more than anything else is bringing the message back to the REMSCO about the BLS 12 lead programs. Because we don't have enough BLS agencies doing 12 leads, if they were it would be a quick solution.

MR. VIOLANTE: Speaking to Dr. VanRoekens' first point about EMS and data, and Dr. Larsen and everyone, as well having worked in trying to get feedback from hospitals to EMS providers through this electronic means for probably seven years now a lot the hospitals are -- want to do this. I should say that most of the personnel in the hospitals want to do this, but there are some difficulties within the hospital that admins and medical directors and such may face. One of those being, are we able to get this data out? It's a liability, we don't want to do it, there is HIPAA and this and

that. In a lot of progressive systems this is working really well to this point. Would it behoove any of the hospitals here to have a standing from the REMAC that says this organization completely advocates for the sharing of data among interfacility hospitals and among EMS? That it is relevant, part of QA/QI, it's in CFR Public Health Law, general municipal regulations, and a hospital should do this.

DR. RABRICH: I think that the HIPAA issue is misinterpreted by a lot of people. It's clearly in the law that feedback to EMS is included, but it might be worth a letter from the REMAC, or perhaps even the SEMAC, a doctor CEO letter, commissioner, to say, please be advised not only is it encouraged, you are required to share this information.

MR. PARRISH: In support of that, it's Article 30, and I think it's 405-19 of the hospital code and joint commission.

MR. JENSEN: In my individual efforts that would be a very assistive letter.

DR. PAPISH: Anybody have a motion? We

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could make a vote to send this out.

DR. VANROEKENS: I move Dr. Papish draft a letter.

DR. RABRICH: I second that.

DR. PAPISH: I'm glad to, but for the benefit of my hospital it should be --

DR. VANROEKENS: From this body and then go to SEMAC.

DR. RABRICH: Quoting the relevant section --

DR. VANROEKENS: -- of code.

DR. PAPISH: Second?

DR. RABRICH: Second.

DR. PAPISH: Vote?

ALL: Aye.

DR. PAPISH: It's unanimous.

MR. VIOLANTE: Thank you.

DR. PAPISH: We will do that.

Service upgrade?

MR. CRUTCHER: We have a few. For Narcan, Kent Fire, Brewster, Stony Point, Village of Montgomery PD, City of Kingston PD, Walden PD and Tuxedo. CPAP, Brewster, Plattekill, Union Vale, Livingston Manor and

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Woodbourne. Glucometry, Stony Point, Gardiner, Woodbourne. Public access defibrillation, Town of Wallkill and Zen Mountain Monastery. BLS 12 lead, Union Vale, Plattekill, Woodbourne.

MR. HUGHES: They have to be voted on.

DR. RABRICH: I move they all be approved as presented, assuming their paperwork is in order.

MR. CRUTCHER: It is and it is complete.

DR. RABRICH: I move.

DR. PAPISH: Second?

DR. ARSHAD: I second it.

DR. PAPISH: Vote?

(Show of hands.)

DR. PAPISH: It's unanimous.

MR. BENENATI: Do those get added to the website?

MR. CRUTCHER: No.

MR. BENENATI: Would that not be beneficial that we add the -- those that are doing the adjuncts, would that not be appropriate so we can share that information and others see others are doing it? I think

that's great. There are several that are now taking on those adjuncts and I think it would be good for others to see they are out there doing that.

MR. CRUTCHER: We could publish that.

DR. PAPISH: That's a good idea.

MR. PARRISH: I think the idea of putting it on the website, not just publishing it --

MR. BENENATI: That's what I mean, put --

DR. PAPISH: Evaluation subcommittee report? Anything?

DR. ARSHAD: We don't have any cases to review, but if I can take thirty seconds of your time? In regards to getting information back to EMS, I think one of the fundamental philosophies in highly quality care is an interdisciplinary approach. So along those lines we hope to have a collaborative conference EMS, ED, ICU, and we are calling it resuscon -- resuscitation conference -- targeted primarily towards emergency physicians, EMS personnel and intensivists.

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We would love if you all could grab a flier or two and post them in your departments, invite your physicians, local squads, and please share. It's going to be September 13th.

DR. PAPISH: Great. Helicopter committee report? We don't have Dr. Berkowitz.

DR. LARSEN: There is no report, there hasn't been a meeting.

DR. PAPISH: There was RTAC?

DR. LARSEN: There was. I can talk about that.

Basically there were two things, again, ongoing discussion about making sure oxygen is provided in TBI patients and -- traumatic brain injury patients, TBI patients and/or even people whom you have the slightest suspicion there might be a TBI. So, again, there was a review of that data and from the study from Arizona.

And there was also a discussion along the lines of getting EMS more involved in the RTAC, that we were going to start going back

to case presentations. So we were going to try and pick high quality trauma -- intense trauma cases and actually make sure the EMT agencies were informed this particular trauma case was going to be discussed and have them a part of that. So that -- again, to bring more involvement and highlight certain issues in trauma.

DR. PAPISH: Would that be CMI and quality --

DR. LARSEN: Yes, there is. Definitely that will be part of it, so to encourage not only agencies involved in that particular call, but anyone that wants to come they can get credit for EMS.

MR. PARRISH: Is there a way to post these dates?

DR. LARSEN: What is that --

MR. PARRISH: -- post the dates.

DR. LARSEN: Yeah. I'm trying to get them to do a yearly schedule like they used to, but they are kind of going from each one to the next one. And there has been some sort of some turnover in personnel from the

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medical center so hopefully it will, you know, continue on. But I think they are going to try and make it so they put it for the whole year, for four meetings per year.

MR. HUGHES: Right now the next meeting is scheduled for September 14th at Westchester Medical Center.

DR. PAPISH: Okay. QI?

MR. CRUTCHER: Okay. As of tomorrow morning at 9:30 New York State will be turning on the Nemesis 3.4.0 bridge. They are going to start by moving over all the Image Trend clients, one or two agencies at a time starting with the north country, just to make sure everything works the way it's supposed to. We spent the last couple of months going over not just the Nemesis rules, but the New York State data dictionary that was published about a year ago, as well as implementing some of our own local rules. We have two agencies on our regional elite bridge. We have been testing these just to make sure everything is functional. Nemesis 3.4 really does include a tremendous amount

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of data points going from Nemesis 2, which has hundreds, to Nemesis 3.4, which has thousands. We should be able to glean some really good data from that. The more agencies that we have on EPCR the better our data set will be locally. So we are -- really need to do something more to push the rest of these agencies to move towards electronic.

DR. PAPISH: Okay. Protocol committee?

MR. BENENATI: Nothing else to report.

DR. PAPISH: New business? So we sent out -- the Cardizem went out?

MR. HUGHES: Yes.

DR. PAPISH: We sent out REMAC advisory about the Cardizem shortage, as everyone knows it's the latest shortage, and using metoprolol as an alternative, which should be sufficient in the interim.

The other REMAC advisory we sent out was actually sort of old business because we had a discussion several -- couple meetings ago that stemmed out of Orange County regarding psychiatric patients and destinations in

which agencies were experiencing problems in which they were being mandated to divert to much further away psych center instead of going to a local hospital. So that advisory went out as well.

MR. HUGHES: We do have some other shortages we see coming up, morphine and fentanyl. I don't know if there is anything that needs to be addressed at this point, but I think we should be aware of it.

MR. BENENATI: I think what we discussed at protocol committee is we defer to the collaborative group and have them issue them in the event that approvals are required. And so if no one objects to that we will follow-up with the collaborative group.

DR. PAPISH: Sounds good. I don't think that's anything we need to vote on.

SEMAC? You kind of gave a synopsis.

DR. RABRICH: EMS has been funded for additional four years, so they will be around for at least another four years. The new Bureau Director, Ryan Greenberg, introduced himself and asked and extends the invitation

to all agencies across the State, if you could change one thing about EMS what your wish would be? And he said feel free to e-mail him, you know, share that with your regional rep, but he is actively collecting this information across the State to try and understand what people think are the highest priority issues for the State.

DR. PAPISH: I think he's planning on doing the rounds of all the various agencies and REMACs and REMSCOs throughout the State so he is going to probably be at some point coming to one of our meetings.

Pad, EpiPen, Narcan?

MR. CRUTCHER: We just did that.

DR. PAPISH: Just did it.

Open forum?

MR. VIOLANTE: A couple, at the last meeting we talked about the regional report for MIST in a prehospital reporting procedure. We all liked it, but didn't have quorum --

DR. PAPISH: Yes.

DR. LARSEN: Just a note on that,

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Westchester REMAC has gone ahead and we have approved that too. So we actually have had a vote and approved the using of the MIST form. Now, educating and getting people to do it is --

MR. VIOLANTE: Part two.

MR. HUGHES: The RTAC was also on board with this and voted too. As long as we say yes that we have approved it, they will start working from their end on implementing it.

DR. RABRICH: We should provide that information to the collaborative group because that's not actually in the collaborative, so I think they passed the baton. We may want to suggest they consider MIST for the collaborative protocols.

DR. PAPISH: Is everybody familiar with MIST from prior meetings, the standardized report?

DR. LARSEN: One more point. Anyone who is going to get the Twiage system, this is incorporated into the Twiage system.

MR. JENSEN: Twiage is aware and the IT department is working on it.

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DR. RABRICH: And they are happy to make changes as we want.

DR. LARSEN: So shoot that in there.

DR. PAPISH: So did we have a motion to -- somebody make a motion?

MR. HUGHES: I can't --

DR. PAPISH: I make a motion to adopt the regional EMS radio report as a standardized format for pre hospital communication to the hospitals.

Do I have a second?

DR. ARSHAD: I would like to second that.

DR. RABRICH: That was good -- she heard you.

DR. PAPISH: Vote? All?

ALL: Aye.

DR. PAPISH: It's unanimous.

DR. LARSEN: Just a report from -- since we weren't officially listed in the agenda -- a report from the Westchester REMAC.

So a couple things, we are establishing a TAG to talk about RSI single provider because down by us it's a two provider -- two

paramedic thing. And there's been pretty extensive discussion, there is national literature on it, that it can be done successfully and safely with one provider. So, you know, right now it's kind of an agency based skill in some ways. And we are thinking about developing it so more -- it's a provider based skill that you carry with you and if the agency is an agency that does RSI then you bring that in and you are capable of doing single providers. So, anyway, we are doing a TAG on it. We will bring those results hopefully by September, the September meeting. So that's one issue that is out there.

We are also doing a TAG on timely PCR transmission. So along the lines of the electronic -- now pretty much everyone in the Westchester area is doing electronic PCR, but the problem is they are still not getting to the hospitals in a timely manner, or at all. So that's a huge issue. So it's not showing up in the patient's record, it's not being a part of the emergency department's decision

on how to handle a patient and that kind of stuff. I mean, at our hospital, White Plains Hospital, we have tried a program -- very moderate success, at the most -- and that is that we are actually having the ED physician sign off on the PCR and timing it. Just like when they get handed an EKG they have to put their name on, time on it. So we are trying to do that, but we are trying to area wide in Westchester figure out how to get these things in timely and get them as part of the record. So that's another TAG.

We have a third TAG that we are talking about, TXA. So I don't know if people want to talk about TXA here, but a lot of folks are, certainly the military experience and TCC courses are all pushing TXA and trauma. And it seems to be fairly good data there that TXA helps. Now, also, you know this is a discussion that is going on in the RTAC and now there is controversy in the RTAC and certainly some trauma surgeons that have questions about TXA. But anyway, we decided to convene a TAG about that and would be very

interested in any discussions here about TXA.

And then, finally, I think for final approval on our June 18th meeting is -- and I'm not sure why this is still an open issue -- but the question of approval that any call audit in Westchester is good for Hudson Valley. So I think that's --

DR. PAPISH: We endorsed that.

DR. LARSEN: I don't think we ever officially approved it in Westchester for some reason.

DR. PAPISH: Are you saying Westchester did you not accept Hudson Valley call audit?

DR. LARSEN: People are still presenting two sheets and this kind of stuff and they shouldn't have bother with all that garbage --

MS. FRAZIER: Sharon Frazier from Mid Hudson. So if -- you are saying if Hudson Valley holds a call audit we can submit it to Westchester to give the Westchester provider?

DR. LARSEN: You --

DR. PAPISH: I think we have been doing that --

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(Everyone is speaking at once.)

DR. LARSEN: It's just like --

MR. PARRISH: Isn't the same thing in place for REMO, they accept ours?

MR. JENSEN: We are doing the same thing with REMO. So we have adopted a uniform form that has both REMO and Hudson Valley REMAC numbers, because they can be different. So they put that on a singular form and it's sent to both agencies.

DR. LARSEN: It seems that anyone who is practicing under the collaborative protocols --

DR. RABRICH: I was going to have a general collaborative form --

DR. LARSEN: -- should be all 13 or however many regions.

DR. PAPISH: All the regions have whether it's call audit credit versus CME.

DR. RABRICH: But you should be able to submit a single form across the collaborative that each region can credit to.

DR. PAPISH: Maybe that is something to suggest to the collaborative protocols since

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everyone is using the same protocols.

MR. VIOLANTE: I have one other thing.

We talked about this a little in the protocol committee and had a number of agencies actually request this, that we expand the use of nitrous oxide from adults to pediatric patients. It's been done in dentistry since about the 1700s so we thought we'd be a little progressive with this bit in the area where we are sort of having potential alternatives to narcotics because morphine is going out in mid summer, fentanyl out in early fall, those kinds of issues. This might be a good time to say, let's use it for pediatric patient. We debated do we use age or what? We came up with the idea of old enough to have the ability to comprehend, follow directions and self-administer, which is just about the same for adults. Actually, if adults can't do that they shouldn't be getting it either. The contraindications are the same, suspected bowel obstruction, pneumothorax and inability to self-administer. We have a high instance of

isolated pediatric trauma this will work well for instead of administering opiates.

So we wanted to pass this through the REMAC first and then also potentially make it a change to the collaborative.

DR. RABRICH: So I actually had a conversation with Dailey regarding this specific issue. It was never the intent of the collaborative to exclude pediatric patients when that protocol was written, it was just written that way. And most of the collaborative physicians when we talked about it feel it's perfectly appropriate for peds. It is just the protocol was never written that way, more of an oversight then intent to exclude peds.

MR. VIOLANTE: Is it possible we -- I don't know if this is possible -- to have the REMAC authorize the use in Hudson Valley Region for pediatric patients under the same auspices and then bring this to the collaborative group for a change?

DR. RABRICH: So it's a protocol change, it would have to go SEMAC if REMAC approves

it.

MR. BENENATI: It might be best to get this body at this point to approve and then go to the collaborative for revisions in the fall. Now is a good time to get in on the rewrite if this body would approve it now --

(The speaker cannot be heard.)

DR. RABRICH: I don't believe you can change the protocol.

DR. ARSHAD: I think that represents a great opportunity for us to educate ourselves more on the use of nitrous oxide. I think it's an excellent modality that is, again, non opiate for the control of pain. But even though there are whole bunch of emergency physicians sitting at this table I don't think nitrous oxide is part of all of our daily practices. I think it certainly represents an opportunity to further educate, not only this body, but to develop training protocols for agencies that are using it for adult populations and to continue growing the awareness, application, and number of agencies that are carrying it on their

formulary.

MR. VIOLANTE: A lot of the equipment has not been completely available until more recently so I'm very happy to sit on a group to do that, to help agencies also write their policies that they would need to write for the use of it and that sort of thing.

DR. LARSEN: Quick poll, does anyone in this room use it in their emergency department or have it available?

DR. PAPISH: Exactly.

DR. VANROEKENS: Right.

DR. PAPISH: It's more cost --

DR. RABRICH: -- logistics.

DR. PAPISH: Is there a draft protocol we could --

MR. VIOLANTE: It's in the protocols.

DR. PAPISH: -- just adding it to the adult protocol and expanding the age.

MR. VIOLANTE: It's in the adult collaborative, it's not in the pediatrics one. That's where we want to move it.

DR. ARSHAD: How many uses of nitrous oxide does Arlington have, for example, in

the last 365 days? Do you have indication, call types, or injury patterns?

DR. RABRICH: That was Dailey's comment too, we don't have a ton of data on its use.

MR. VIOLANTE: When we actually went to the collaborative protocols, in essence it was out of the protocol and we worked with Pam and Dr. Dailey to put it in. And Arlington, Shandaken, New Windsor and --

MR. BENENATI: Ellenville.

MR. VIOLANTE: -- Ellenville did a study of the efficacy of nitrous oxide in the prehospital environment, pulled all our data together, did a report. I'm happy to send that to group. We gave it to Dr. Dailey, he said, okay, sounds great, and put it in. We did a follow-up study on nitrous oxide in the ambulances and things that we would need to change environmentally for appropriate use. I can send that out as well to this group to help in that decision.

So those agencies using it -- for Arlington, to answer your question, we have probably two, three, four uses a month. It

increases in the summertime for us.

DR. ARSHAD: Orthopedic injuries.

MR. VIOLANTE: Orthopedic, injuries in places like Shandaken it increases over wintertime because of skiing accidents. So it's used. And, again, it's becoming more available. It's a great tool especially if you need to use it to stabilize a person to be able to move them when they actually don't need narcotics in the long-term, but you know, in the short-term and/or until you are able to get some narcotics on board it's a good intermediary device.

DR. PAPISH: Do we have a motion? Do we want to push this through?

DR. ARSHAD: I'm interested in learning more about it. It sounds like a fantastic opportunity. At this point in time I don't have enough hands-on experience to recommend protocol changes, or -- you know, patient population that -- I'm not that familiar with the drug itself and the effect on that patient population.

DR. RABRICH: I move we refer to

protocol committee for preparation at the next meeting maybe more data. It sounds like people need more familiarity with how it's used, maybe a brief presentation might be helpful.

MR. VIOLANTE: Sure, okay. When do the changes need to be in for the collaboratives?

MR. BENENATI: Again, they are hoping to get that approval in September.

DR. RABRICH: That doesn't mean you can't suggest it to the collaborative now --

(Everyone is speaking at once.)

MR. BENENATI: -- but it's just this group would like a presentation at the next meeting.

MR. VIOLANTE: Fair enough.

DR. RABRICH: I certainly would let the collaborative know now.

DR. PAPISH: Other new business?

MR. HUGHES: Just a point of information. The REMSCO approval, the expansion of territory for Hatzolah of Rockland to include all of Rockland as their primary territory at the last REMSCO meeting

this week. What happens from this point on, all the paperwork gets signed from the REMSCO, it's submitted to the State and the State will wait 30 days to see if there is any kind of an appeal process. If it hasn't they will issue the certificate for that expansion.

The second thing that was going to be -- will be coming here shortly is the Village of New Square Volunteer Ambulance Corp in Rockland County submitted an application to upgrade to ALS. The application was reviewed and referred back to the agency for a couple inconsistencies and few questions. Hopefully that will be clarified and brought here, we will create a TAG and the TAG will review the application, make sure everything makes sense in the way it operates. And then there will be a public meeting where anybody within the public or within the county can come and speak about whether or not they should have or shouldn't have ALS upgrade and it will be brought to here as a system upgrade.

DR. PAPISH: Okay.

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MR. HUGHES: Probably at the next meeting.

MR. PARRISH: Bill, you want to talk about the New Windsor one?

MR. HUGHES: Yeah, we can do that.

We also have a certificate of -- expansion of territory for New Windsor Ambulance to cover -- to include as their primary territory the Town of Cornwall. That was also reviewed, sent back to them, they had a bunch of things that had to be corrected. And we just got that back Friday night so we haven't had a chance to look and make sure the corrections are in. So the REMSCO will create a TAG and transportation will vote and present it to the REMSCO at probably the next REMSCO meeting.

DR. PAPISH: Okay.

DR. LARSEN: Just a short discussion about shortages. So, you know, I'm not sure what agencies are having shortages here, we actually put out some memos in terms of the use of beta blocker instead of Cardizem because no one can get Cardizem. And also

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for those agencies doing RSI, people are having troubling getting succinylcholine. So now within the formulary from the collaborative protocols, you know, there is -- rocuronium is already in there so, you know, there is not a big jump there. It's not like we are having to introduce any kind of new medication. I mean, they are there in the formulary, but they are not the first choice for those two particular problems, so whatever --

DR. PAPISH: I feel like -- didn't we send an advisory like a year or two ago about that?

MR. CRUTCHER: Yep.

DR. PAPISH: The same thing, all right. And we sent out the Cardizem one?

MR. HUGHES: Yep.

DR. PAPISH: It will be an ongoing problem, obviously, unless there is some reform in how they make these.

Any other open forum?

New business?

Motion to adjourn?

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DR. BUTTERFASS: Motion.

DR. RABRICH: Second.

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

Yvette Arnold